TUFTS MEDICARE COMPLEMENT
EVIDENCE OF COVERAGE

EFFECTIVE JULY 1, 2008

TUFTS Health Plan
No one does more to keep you healthy.

Commonwealth of Massachusetts
Group Insurance Commission

Tufts Health Plan Address And Telephone Directory

TUFTS HEALTH PLAN
705 Mount Auburn Street
Watertown, Massachusetts 02472-1508

Hours:
Monday, Tuesday, and Thursday from 8:00 a.m. to 7:00 p.m. E.S.T.
Wednesday from 8:00 a.m. to 10:00 a.m. and 11:30 a.m. to 7:00 p.m. E.S.T.
Friday from 8:00 a.m. to 5:00 p.m. E.S.T.

IMPORTANT PHONE NUMBERS:

Emergency or *Urgent Care*

In an *Emergency*, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.

If you need and cannot reach your *PCP* or your *PCP's Covering Physician*, you should seek care at the nearest emergency room. For routine care you should always call your *PCP* before seeking care.

Liability Recovery

Call the *Plan's* Liability and Recovery Department at 1-888-880-8699, extension 1098 for questions about "coordination of benefits". For example, call the Liability and Recovery Department if you have any questions about how *Tufts Health Plan* coordinates coverage with other health care coverage that you may have. The Liability and Recovery Department is available from 8:30 a.m. – 5:00 p.m. Monday through Thursday and from 10:00 – 5:00 p.m. on Friday. For questions related to subrogation, call the Member Services Department at 1-800-870-9488.

For more information about coordination of benefits (COB) and subrogation, see page 6-3.

Medicare

Contact your local Social Security office or visit the Web site at **www.medicare.gov**.

Member Services Department

Call for general questions, assistance in choosing a *Primary Care Physician* (*PCP*), benefit questions, and information regarding eligibility for enrollment and billing. 1-800-870-9488.

Mental Health Services

If you need assistance in receiving information regarding mental health professionals in your area, please contact the Mental Health department at 1-800-208-9565.

Services for Hearing Impaired *Members*

If you are heading impaired, the following services are provided:

Telecommunications Device for the Deaf (TDD)

If you have access to a TDD phone, call **1-800-868-5850**. You will reach the Member Services Department.

Massachusetts Relay (MassRelay)

1-800-720-3480

IMPORTANT ADDRESSES:

Appeals and Grievances Department
If you need to call *Tufts Health Plan* about a concern or appeal, contact Member Services at 1-800-870-9488. To submit your Appeal or Grievance in writing, send your letter to:

Tufts Health Plan
Attn: Appeals and Grievances Department
705 Mount Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193

Web site
For more information about *Tufts Health Plan* and to learn more about the self-service options that are available to you, please see the *Tufts Health Plan* Web site at **www.tufts-healthplan.com**.

Translating services for 140 languages

Interpreter and translator services related to administrative procedures are available to assist *Members* upon request. For information, please call the Member Services Department.

خدمات المترجمين والترجمة المتعلقة بالإجراءات الإدارية متوفرة لمساعدتك في هذا الشأن. لطلب هذه الخدمات، الرجاء الاتصال بقسم علاقات الزبون التابع لخطة "تفتس هلس بلان".

អ្នកបកប្រែភាសា និងកិច្ចការបកប្រែទាំងឡាយ ដែលជាប់ទាក់ទងនឹងទំរង់ការខាងការចាត់ចែងការ គឺមានផ្តល់សំរាប់ជួយអ្នក ។ ដើម្បីស្នើសុំការបំរើទាំងនេះ សូមទូរស័ព្ទមកក្រសួងទំនាក់ទំនងភ្ញៀវ នៃគំរោងថែរក្សាសុខភាពរបស់ Tufts ។

相關管理程序的口譯和筆譯服務隨時爲您提供協助。如需要這些服務，請打電話給「Tufts 健康計劃顧客聯絡部」。

Des services d'interprétariat et de traduction liés aux procédures administratives sont disponibles. Pour demander ces services, veuillez contacter le département des relations avec la clientèle de Tufts Health Plan.

Για την εξυπηρέτησή σας, υπάρχουν διαθέσιμες υπηρεσίες ερμηνείας και μετάφρασης σχετικά με τις διοικητικές διαδικασίες. Για να ζητήσετε αυτές τις υπηρεσίες, τηλεφωνήστε στο Τμήμα Πελατειακών Σχέσεων του Προγράμματος Ιατροφαρμακευτικής Ασφάλισης Tufts.

ພວກເຮົາມີບໍລິການນາຍພາສາແລະການແປເອກະສານທາງດ້ານວິທີດຳເນີນການຫຸລະການໄວ້ ບໍລິການທ່ານ. ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຂອງແຜນສຸຂະພາບທັຟສ Tufts , ຖ້າຕ້ອງການບໍລິການເຫລົ່ານີ້.

Temos disponíveis serviços de tradução e interpretação relacionados aos procedimentos administrativos. Para obter estes serviços, ligue para o departamento de relações com o cliente do Tufts Health Plan.

С целью оказать Вам помощь по административным процедурам предлагаются устные и письменные переводческие услуги. Если Вам нужны эти услуги, позвоните, пожалуйста, в Отдел связей с клиентами Плана здравоохранения «Тафтс» Tufts.

Los servicios de traducción e interpretación en relación a procedimientos administrativos están disponibles para ayudarle. Para solicitar este servicio, favor de llamar al departamento de relaciones con el cliente de Tufts Health Plan.

Genyen sèvis tradiksyon ak entèprèt disponib pou ede ou nan zafè ki gen rapò ak jan administrasyon an fè sèvis li. Pou ou mande sèvis sa yo, tanpri rele depatman sèvis kliyan Tufts Health Plan.

Sono disponibili servizi di traduzione e interpretariato relativamente alle procedure amministrative. Per richiedere tali servizi, contattare l'ufficio relazioni clienti del *Tufts Health Plan*.

1-800-870-9488

TDD

Telecommunications Device for the Deaf:

1-800-868-5850

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Chapter 1
How Your HMO Plan Works

Overview

Introduction

Welcome to the *Tufts Health Plan* Medicare Complement Plan ("TMC Plan"). We are pleased you have chosen us. We look forward to working with you to help you meet your health care needs. Your satisfaction with *Tufts Health Plan* ("the Plan") is important to us. If at any time you have questions, please call Member Services at 1-800-870-9488 and we will be happy to help you.

The Tufts Medicare Complement Plan, in conjunction with Medicare, offers a comprehensive package of medical benefits. The TMC Plan is designed to add to your Medicare coverage (Parts A and B of the Original Medicare Program), subject to the terms, conditions, exclusions and limitations of Medicare eligible services.

Under the TMC Plan, coverage is provided for certain services which are not covered under Medicare Parts A and B. Those services include:

- preventive care, including routine health exams, annual vision and hearing screenings; and
- prescription drug coverage.

Eligibility for Benefits under this TMC Plan

You have chosen to participate in a managed health care network in which you and your *Primary Care Physician* ("*PCP*") play the most important roles. *Tufts Health Plan* is a health maintenance organization which arranges for your health care through a network of health care professionals and hospitals. When you join *Tufts Health Plan* you will need to choose a *Primary Care Physician* ("*PCP*") to manage your care. Your *PCP* is a physician in private practice who personally cares for your health needs, and if the need arises, refers you to a specialist within the *Tufts Health Plan* network.

By joining the TMC Plan, you agree to receive your care from *Plan Providers*. If you fail to do this

- the *Plan* will not provide benefits for either Medicare-eligible services or the additional *Covered Services* available under this plan, and
- you will be responsible for any Medicare Part A and B *Deductible* and *Coinsurance* amounts.

The *Plan* covers only the services and supplies described as *Covered Services* in Chapter 3. There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

Evidence of Coverage

This book, called your *Evidence of Coverage*, will help you find answers to your questions about *Plan* benefits. The *Plan* certifies that you have the right to services and supplies described in this *Evidence of Coverage* which are *Medically Necessary* and authorized by your *PCP*.

The benefits described in this *Evidence of Coverage* are available as established by Massachusetts General Law Chapter 176G. Under the provisions of the Tufts Medicare Complement Plan, Medicare is the **primary insurer** and the *Plan* is the **secondary insurer**.

Coverage will be subject to the terms, conditions, exclusions, and limitations of eligible services and supplies under the Original Medicare Plan. That coverage is subject to change per Medicare's guidelines. This *Evidence of Coverage* is not intended as a full explanation of Medicare's benefits. Information and guidelines established for Medicare by the federal Centers for Medicare and Medicaid Services may be obtained:

- by contacting your local Social Security office; or
- via the internet on the official Medicare Web site at **www.medicare.gov**.

In addition, please refer to your Medicare Handbook for any questions pertaining to the Medicare portion of your health care under this TMC plan.

Please note that words with special meanings appear as italicized words in this *Evidence of Coverage*. Those words are defined in the Glossary in Appendix A.

Calls to Member Services

The Member Services Department is committed to excellent service.

Calls to the Member Services Department may on occasion be monitored by supervisors to assure quality service.

How the Plan Works

Primary Care Physicians

Each *Member* must choose a *Primary Care Physician* (*PCP*) who will provide or authorize care. If you do not choose a *PCP*, the *Plan* will not pay for any services or supplies except for *Emergency* care.

***Medically Necessary* services and supplies**

The *Plan* will pay for *Covered Services* and supplies when they are *Medically Necessary*.

Important: The *Plan* will not pay for services or supplies which are not *Covered Services*, even if they were provided or authorized by your *PCP*.

The *Plan's Service Area*

In most cases, you must receive your care in the *Service Area*. The exceptions are for an *Emergency*, or *Urgent Care* while traveling outside of the *Service Area*.

For information about the *Service Area*, see the *Directory of Health Care Providers* or contact *Member Services.*

Changes to the *Plan's Provider* network

The *Plan* offers *Members* access to an extensive network of physicians, hospitals, and other *Providers* throughout the *Service Area*. Although the *Plan* works to ensure the continued availability of *Plan Providers*, the *Plan's* network of *Providers* may change during the year.

This can happen for many reasons, including a *Provider's* retirement, moving out of the *Service Area*, or failure to continue to meet the *Plan's* credentialing standards. In addition, because *Providers* are independent contractors who do not work for the *Plan*, this can also happen if the *Plan* and the *Provider* are unable to reach agreement on a contract.

If you have any questions about the availability of a *Provider*, please call Member Services at 1-800-870-9488.

Comparison of coverage

The table below tells you if coverage exists, depending on the type of care you receive and the place you receive care.

IF you…	AND you are…	THEN…
receive routine health care services	in the *Service Area*	you are covered, if you receive care through your *PCP*.
	outside the *Service Area*	you are <u>not</u> covered.
are ill or injured	in the *Service Area*	you are covered, if you receive care through your *PCP*.
	outside the *Service Area*	you are covered for *Urgent Care*.
have an *Emergency*	in the *Service Area*	you are covered.
	outside the *Service Area*	you are covered.

Continuity of Care

If you are an existing *Member*

If your *Provider* is involuntarily disenrolled from the *Plan* for reasons other than quality or fraud, you may continue to see your *Provider* in the following circumstances:

- Pregnancy. If you are in your second or third trimester of pregnancy, you may continue to see your *Provider* through your first postpartum visit.
- Terminal Illness. If you are terminally ill (having a life expectancy of 6 months or less), you may continue to see your *Provider* as long as necessary.

If your *PCP* disenrolls, the *Plan* will provide you notice at least 30 days in advance. If the disenrollment is for reasons other than quality or fraud, you may continue to see your *PCP* for up to 30 days after the disenrollment.

To choose a new *PCP*, call Member Services at 1-800-870-9488. The Member Services Coordinator will help you to select one from the *Directory of Health Care Providers*. You can also visit the *Plan*'s Web site at **www.tuftshealthplan.com** to choose a *PCP*.

If you are enrolling as a new *Member*

When you enroll as a *Member*, if none of the health plans offered by the *Group Insurance Commission* at that time include your *Provider*, you may continue to see your *Provider* if:

- you are undergoing a course of treatment. In this instance, you may continue to see your *Provider* for up to 30 days from your *Effective Date*.
- the *Provider* is your *PCP*. In this instance, you may continue to see your *PCP* for up to 30 days from your *Effective Date*;
- you are in your second or third trimester of pregnancy. In this instance, you may continue to see your *Provider* through your first postpartum visit;
- you are terminally ill. In this instance, you may continue to see your *Provider* as long as necessary.

Conditions for coverage of continued treatment

The *Plan* may condition coverage of continued treatment upon the *Provider's* agreement:

- to accept reimbursement from the *Plan* at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to a *Member* in an amount that would exceed the cost sharing that could have been imposed if the *Provider* has not been disenrolled;
- to adhere to the quality assurance standards of the *Plan* and to provide the *Plan* with necessary medical information related to the care provided; and
- to adhere to the *Plan* policies and procedures, including procedures regarding referrals, obtaining prior authorization, and providing services pursuant to a treatment plan, if any, approved by the *Plan*.

About Your *Primary Care Physician*

Importance of choosing a *PCP*

Each *Member* must choose a *PCP* when he or she enrolls. The *PCP* you choose will be associated with a specific *Provider Unit*. This means that you will usually receive *Covered Services* from health care professionals and facilities associated with that *Provider Unit*. Once you have chosen a *PCP*, you are eligible for all *Covered Services*.

> **IMPORTANT NOTE:** Until you have chosen a *PCP*, only *Emergency* care is covered by *Tufts Health Plan*.

What a *PCP* does

A *PCP*:

- provides routine health care (including routine physical examinations),
- arranges for your care with other *Plan Providers*, and
- provides referrals for other health care services, except for mental health services. See "Inpatient and intermediate mental health/substance abuse services" on page 3-23 for more information about obtaining referrals for these services.

Your *PCP*, or a *Covering Physician*, is available 24 hours a day.

Your *PCP* will coordinate your care by: treating you, or referring you to specialty services.

Choosing a *PCP*

You must choose a *PCP* from the list of *PCPs* in the *Directory of Health Care Providers*. If you already have a physician who is listed as a *PCP*, in most instances you may choose him or her as your *PCP*.

If you do not have a physician or your physician is not listed in the *Directory of Health Care Providers*, call Member Services at 1-800-870-9488 for help in choosing a *PCP*.

Notes:

- Under certain circumstances required by law, if your physician is not in the *Tufts Health Plan* network, you will be covered for a short period of time for services provided by your physician. A Member Services Coordinator can give you more information. Please see "Continuity of Care" on page 1-5.
- For additional information about a *PCP* or specialist, the **Massachusetts Board of Registration in Medicine** provides information about physicians licensed to practice in Massachusetts. You may reach the Board of Registration at (617) 654-9800 or **www.massmedboard.org.**

Contacting your new *PCP*

If you have chosen a new physician as your *PCP*, you should:

- contact your new *PCP* as soon as you join and identify yourself as a new *Plan Member*,
- ask your previous physician to transfer your medical records to your new *PCP*, and
- make an appointment for a check-up or to meet your *PCP*.

If you can't reach your *PCP*

Sometimes you may not be able to reach your *PCP* by phone right away. The table below explains what you should do if this happens.

IF…	THEN…
your *PCP* cannot take your call at once	always leave a message with the office staff or answering service. Wait a reasonable amount of time for someone to return your call. If your call is not returned, and this happens during a weekday, please call Member Services at **1-800-870-9488.** If this occurs during a night or weekend, you will need to follow the steps below for obtaining medical services after hours.
you need medical services after hours	please contact your *PCP* or a *Covering Physician*. Your *PCP*, or a *Covering Physician*, is available 24 hours a day, 7 days a week. If you need *Inpatient* mental health or substance abuse services after hours, please call 1-800-208-9565 for assistance.

Note: If you are experiencing a medical *emergency*, you do not have to contact your *PCP* or a *Covering Physician*; instead, proceed to the nearest emergency medical facility for treatment (see "When You Need *Emergency* or *Urgent Care*" below for more information).

Changing your *PCP*

You may change your *PCP* or, in certain instances, the *Plan* may require you to do so. The new physician will not be considered your *PCP* until:

- you choose a new *PCP* from the *Directory of Health Care Providers*;
- you report your choice to Member Services at 1-800-870-9488; and
- the *Plan* approves the change in your *PCP*.

Then, the *Plan* will send you a new Member ID card listing your new *PCP*.

Note: You may not change your *PCP* while you are an *Inpatient* or in a partial hospitalization program.

Canceling appoint-ments

If you must cancel an appointment with any *Provider*:

- always provide as much notice to the *Provider* as possible (at least 24 hours), and
- if your *Provider's* office charges for missed appointments that you did not cancel in advance, the *Plan* will not pay for the charges.

Referrals for specialty services

Every *PCP* is associated with a specific *Provider Unit*. If you need to see a specialist (including a pediatric specialist or a pediatric mental health specialist), your *PCP* will select the specialist and make the referral. Usually, your *PCP* will select and refer you to another *Provider* in the same *Provider Unit* (as defined in Appendix A). Because the *PCP* and the specialists already have a working relationship, this helps to provide quality and continuity of care.

If you need specialty care that is not available within your *PCP's Provider Unit* (this is an uncommon event), your *PCP* will choose a specialist in another *Provider Unit* and make the referral. When selecting a specialist for you, your *PCP* will consider any long-standing relationships that you have with any *Plan Provider*, as well as your clinical needs. (As used in this section, a long-standing relationship means that you have recently been seen or been treated repeatedly by that *Plan* specialist.)

If you require specialty care which is not available through any *Plan Provider* (this is a rare event), your *PCP* may refer you, with the prior approval of an *Authorized Reviewer*, to a *Provider* not associated with the *Plan*.

Notes:

- A referral to a specialist must be obtained from your *PCP* **before** you receive any *Covered Services* from that specialist. If you do not obtain a referral **prior** to receiving services, you will be responsible for the cost of those services.
- *Covered Services* provided by non-*Plan Providers* are not paid for unless authorized in advance by your *PCP* and approved by an *Authorized Reviewer*.
- For mental health and substance abuse services, you do not need a referral from your *PCP*; however, may need authorization from a *Tufts HP* Mental Health *Authorized Reviewer*. See "*Inpatient* mental health and substance abuse services" and "*Outpatient* mental health and substance abuse services" on pages 3-23 and 3-24 for more information.

Referral forms for specialty services

Except as provided below, your *PCP* must complete a referral every time he or she refers you to a specialist. Sometimes your *PCP* will ask you to give a referral form to the specialist when you go for your appointment. Your *PCP* may refer you for one or more visits and for different types of services. Your *PCP* must approve any referrals that a specialist may make to other *Providers*. Make sure that your *PCP* has made a referral before you go to any other *Provider*. A *PCP* may authorize a standing referral for specialty health care provided by a *Plan Provider*.

***Authorized Reviewer* approval**

If the specialist refers you to a non-*Plan Provider*, the referral must be approved by your *PCP* and an *Authorized Reviewer*. In addition, certain *Covered Services* described in Chapter 3 must be authorized in advance by an *Authorized Reviewer*, or, for mental health or substance abuse services from a *Tufts HP* Mental Health *Authorized Reviewer*. If you do not obtain that authorization, the *Plan* will not cover those services and supplies.

When referrals are not required

The following *Covered Services* do not require a referral or prior authorization from your *Primary Care Physician*. Except as detailed on page 3-1, or for *Urgent Care* outside of the *Service Area*, or for *Emergency* care, you must obtain these services from a *Plan Provider*:

- *Emergency* Care in an Emergency Room or physician's office. (Note: If you are admitted as an *Inpatient*, you or someone acting for you must call your *PCP* or *Tufts Health Plan* within 48 hours after receiving care. Notification from the attending physician satisfies this requirement.)

- Mammography screenings at the following intervals:

  - one baseline at 35-39 years of age;
  - one every year at age 40 and older; or
  - as otherwise *Medically Necessary*.

- *Urgent Care* outside of the *Service Area.* (Note: You must contact your *PCP* after *Urgent Care Covered Services* are rendered for any follow-up care.)

- Pregnancy terminations.

- Routine annual eye exam.

- Spinal Manipulation

- The following specialty care provided by a *Plan Provider* who is an obstetrician, gynecologist, certified nurse midwife or family practitioner:

  - Maternity Care.

  - *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions.

  - Routine annual gynecological exam, including any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam.

Financial Arrangements between the *Plan* and *Plan Providers*

Methods of payment to *Plan Providers*

The *Plan's* goal in compensating *Providers* is to encourage preventive care and active management of illnesses. The *Plan* strives to be sure that the financial reimbursement system we use encourages appropriate access to care and rewards *Providers* for providing high quality care to our *Members*. *Tufts Health Plan* uses a variety of mutually agreed upon methods to compensate *Plan Providers*.

The *Directory of Health Care Providers* indicates the method of payment for each *Provider*. Regardless of the method of payment, the *Plan* expects all participating *Providers* to use sound medical judgment when providing care and when determining whether a referral for specialty care is appropriate. This approach encourages the provision of *Medically Necessary* care and reduces the number of unnecessary medical tests and procedures which can be both harmful and costly to *Members*.

The *Plan* oversees the provision of care through its Quality of Health Care Program. You should feel free to discuss with your *Provider* specific questions about how he or she is paid.

Member Identification Card

Introduction

The *Plan* gives each *Member* a Member identification card (Member ID card).

Reporting errors

When you receive your Member ID card, check it carefully. If any information is wrong, call Member Services at 1-800-870-9488.

Using your card

Your Member ID card is important because it identifies your health care plan. Please remember to:

- carry your card at all times;
- have your card with you for medical, hospital and other appointments; and
- show your card to any *Provider* before you receive health care.

Member Identification Card, Continued

Identifying yourself as a *Member*

Your Member ID card is important because it identifies your health care plan. Please:

- carry your card at all times;
- have your card with you for medical, hospital and other appointments; and
- show your card to any *Provider* before you receive health care.

When you receive services, you must tell the office staff that you are a *Tufts Health Plan Member*.

IMPORTANT NOTE: If you do not do this, and, as a result, your *PCP* or the *Plan* does not manage your care, then

- the *Plan* may not pay for the services provided, and
- you may be responsible for the costs.

Membership requirement

You are eligible for benefits if you are a *Member* when you receive care. A Member ID card alone is not enough to get you benefits. If you receive care when you are not a *Member*, you are responsible for the cost.

Membership Identification Number

If you have any questions about your Member Identification Number, please call Member Services at 1-800-870-9488.

Utilization Management

Introduction

This section describes the *Plan's* utilization management program.

Utilization management

Tufts Health Plan has a utilization management program. The purpose of the program is to control health care costs by evaluating whether health care services provided to *Members* are *Medically Necessary* and provided in the most appropriate and efficient manner. Under this program, the *Plan* sometimes engages in prospective, concurrent, and/or retrospective review of health care services.

The *Plan* uses prospective review to determine whether proposed treatment is *Medically Necessary* before that treatment begins. Prospective review is also referred to as "Pre-Service Review".

The *Plan* engages in concurrent review to monitor the course of treatment as it occurs and to determine when that treatment is no longer *Medically Necessary*.

Retrospective review is used to evaluate care after the care has been provided. In some circumstances, the *Plan* engages in retrospective review to more accurately determine the appropriateness of health care services provided to *Members*. It is also referred to as "Post-Service Review".

IMPORTANT NOTE: *Members* can call the *Plan* at the following numbers to determine the status or outcome of utilization review decisions.

- Mental health or substance abuse utilization review decisions - 1-800-208-9565;
- All other utilization review decisions - 1-800-462-0224.

Type of Review	Timeframe for Determinations*
Prospective (Pre-Service)	Within 2 working days of receiving all necessary information, but no later than 15 days from receipt of the request.
Concurrent	Determination is made prior to treatment being reduced or terminated to allow you to appeal the determination.
Retrospective (Post-Service)	30 days

Specialty case management

Some *Members* with severe illnesses or injuries may warrant case management intervention under the *Plan's* specialty case management program. Under this program, the *Plan*:

- encourages the use of the most appropriate and cost-effective treatment; and
- monitors the *Member's* treatment and progress.

The *Plan* may contact that *Member* and his or her *Plan Provider* to discuss a treatment plan and establish short and long term goals. The *Tufts Health Plan* Specialty Case Manager may suggest alternative treatment settings available to the *Member*.

The *Plan* may periodically review the *Member's* treatment plan. The *Plan* will contact the *Member* and the *Member's Plan Provider* if *Tufts Health Plan* identifies alternatives to the *Member's* current treatment plan that: qualify as *Covered Services*; are cost effective; and are appropriate for the *Member*.

A severe illness or injury includes, but is not limited to, the following:

- serious heart or lung disease;
- cancer;
- certain neurologic diseases;
- AIDS or other immune system diseases;
- certain mental health conditions, including substance abuse;
- severe traumatic injury;
- high-risk pregnancy.

Individual case management (ICM)

In certain circumstances, the *Plan* may authorize an individual case management ("ICM") plan for a *Member* with a Severe Illness or Injury. The ICM plan is designed to arrange for the most appropriate type, level, and setting of health care services and supplies for the *Member*.

As a part of the ICM plan, the *Plan* may authorize coverage for alternative services and supplies that do not otherwise constitute *Covered Services* for that *Member*. This will occur only if the *Plan* determines, in its sole discretion, that all of the following conditions are satisfied:

- the *Member's* condition is expected to require medical treatment for an extended duration;
- the alternative services and supplies are *Medically Necessary*;
- the alternative services and supplies are provided directly to the *Member* with the condition;
- the alternative services and supplies are in place of more expensive treatment that qualifies as *Covered Services*;
- the *Member* and an *Authorized Reviewer* agree to the alternative treatment program; and
- the *Member* continues to show improvement in his or her condition, as determined periodically by an *Authorized Reviewer*.

When *Tufts Health Plan* authorizes an ICM plan, the *Plan* will also indicate the *Covered Service* that the ICM plan will replace. The benefit available for the ICM plan will be limited to the benefit that the *Member* would have received for the *Covered Service*.

The *Plan* will periodically monitor the appropriateness of the alternative services and supplies provided to the *Member*. If, at any time, these services and supplies fail to satisfy any of the conditions described above, the *Plan* may modify or terminate coverage for the services or supplies provided pursuant to the ICM plan.

When You Are Ill or Injured (Non-*Emergency* Care) within the *Service Area*

Intro-duction

This topic describes what to do when you are ill or injured and you are within the *Service Area*. This includes when you need *Urgent Care* within the *Service Area*.

Rule

Always call your *PCP*. Without authorization from your *PCP*, services will not be covered by the *Plan*.

Important: Never wait until your condition becomes an *Emergency* to call.

Procedure

If you are ill or injured, follow the steps in the table below.

Step	Action
1	Contact your *PCP* and say you are a *Tufts Health Plan Member*.
2	Explain the problem as clearly as possible to the office staff or your *PCP*.
3	After evaluating your problem, your *PCP* will: • provide you care, or • arrange for treatment and specialty care if necessary.

Note: If you need medical services after hours, please contact your *PCP* or a *Covering Physician*. Your *PCP*, or a *Covering Physician*, is available 24 hours a day, 7 days a week. If you need *Inpatient* mental health or substance abuse services after hours, please call 1-800-208-9565 for assistance.

***Inpatient* hospital services**

If you need *Inpatient* services, in most cases you will be admitted to your *PCP's Plan Hospital*.

Transfer to a *Plan Hospital*

If you are admitted to a facility which is not the *Plan Hospital* in your *PCP's Provider Unit*, and your *PCP* determines that transfer is appropriate, you will be transferred to:

- the *Plan Hospital* in your *PCP's Provider Unit*, or
- another *Plan Hospital*.

Important: The *Plan* may not pay for *Inpatient* care provided in the facility to which you were first admitted after your *PCP* has decided that a transfer is appropriate and transfer arrangements have been made.

Charges after discharge hour

If you choose to stay as an *Inpatient* after a *Plan Provider* has scheduled your discharge, the *Plan* will not pay for any costs incurred after the discharge hour.

***Outpatient* mental health/ substance abuse services**

You may obtain a referral to see an *Outpatient* mental health and substance abuse provider if you, your *PCP*, or a *Tufts Health Plan* mental health *Provider* calls the *Plan's* Mental Health/Substance Abuse Referral Service at 1-800-208-9565.

When You Need *Emergency* or *Urgent Care* (whether you are in or out of the *Service Area*)

Guidelines for receiving *Emergency* care

Follow these guidelines when you need *Emergency* care, whether in or out of the *Service Area*.

- If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.
- Go to the nearest emergency medical facility.
- You do not need approval from your *PCP* before receiving *Emergency* care.
- If you receive *Outpatient Emergency* care at an emergency facility, you or someone acting for you should call your *PCP* or the *Plan* within 48 hours after receiving care. You are encouraged to contact your *Primary Care Physician* so your *PCP* can provide or arrange for any follow-up care that you may need.
- If you are admitted as an *Inpatient*, you or someone acting for you must call your *PCP* or the *Plan* within 48 hours after receiving care. (Notification from the attending physician satisfies that requirement.)
- If you receive *Emergency Covered Services* from a non-*Plan Provider*, the *Plan* will pay up to the *Reasonable Charge*. You pay the applicable *Copayment* and any difference between what *Tufts Health Plan* paid and what the non-*Plan Provider* charged for the service.

When You Need *Emergency* or *Urgent Care* (whether you are in or out of the *Service Area*), continued

Guidelines for receiving *Urgent Care*

Follow these guidelines for receiving *Urgent Care*.

If you are in the *Service Area*

- Contact your *PCP* and tell him or her that you are a *Plan Member*.
- Explain your problems as clearly as possible.
- If you are in the *Service Area*, your *PCP* will either provide you with care or will arrange for treatment or specialty care if necessary.

If you are outside the *Service Area*

- If you are outside of the *Service Area*, you may seek *Urgent Care* in a physician's office or the *Emergency* room.
- You or someone acting for you must contact your *PCP* to arrange for any necessary follow-up care.
- The *Urgent Care Provider* may bill the *Plan* directly or may require you to pay for the *Urgent Care* services at the time of service. If you are required to pay, the *Plan* will reimburse you up to the *Reasonable Charge* for *Urgent Care* services received outside of the *Service Area*. You are responsible for the applicable *Copayment* and any difference between what the *Plan* paid and what the Non-*Plan Provider* charged for the service. Please see "Bills from *Providers*" on page 5-11 for more information about how to get reimbursed for *Urgent Care Covered Services* received outside of the *Service Area*.

Important Notes:

- If you are admitted as an *Inpatient* after receiving *Urgent Care Covered Services*, you or someone acting for you must call your *PCP* or the *Plan* within 48 hours after receiving care. (Notification from the attending physician satisfies this requirement.)
- *Urgent* or *Emergency Care* services received outside of the *Service Area* are covered. However, continued services after the *Emergency* or *Urgent* condition has been treated and stabilized may not be covered if the *Plan* determines, in coordination with the *Member's* providers, that the *Member* is safe for transport back into the *Service Area*.
- If you need medical services after hours, please contact your *PCP* or a *Covering Physician*. Your *PCP*, or a *Covering Physician*, is available 24 hours a day, 7 days a week. If you need *Inpatient* mental health or substance abuse services after hours, please call 1-800-208-9565 for assistance.

What to Do When Traveling

Introduction This topic tells you what to do if you need care outside the *Service Area*. When traveling, you must know the types of services that are not covered by the *Plan*.

Coverage outside the *Service Area* The table below lists services that are and are not covered outside the *Service Area*. See the *Directory of Health Care Providers* for *Service Area*.

Type of Service	Example	Coverage
Routine care	• routine general physical examinations; • routine gynecological or obstetrical examinations; • diagnostic tests related to general physical and gynecological examinations; • ongoing treatment for a psychiatric condition; • immunizations to prevent disease; and • other preventive procedures.	Not covered
Elective *Inpatient* Admissions/*Day Surgery*	Admissions or surgery that can be safely delayed until you return to the *Service Area*.	Not covered
Care that could have been foreseen before leaving the *Service Area*	• deliveries within one month of the due date, including postpartum care; • removal of stitches; and • long-term conditions that need ongoing medical care. Exceptions are on a case-by-case basis. Please call Member Services at 1-800-870-9488.	Not covered
*Urgent Care**	• a dislocated toe; • a cut that is not bleeding heavily but needs stitches; • sudden extreme anxiety; • symptoms of a urinary tract infection.	Covered
Emergency care*	• a broken leg; • chest pains; • difficulty breathing; • heavy bleeding; • loss of consciousness; • vomiting blood; • severe pain.	Covered

*Note: If you are admitted as an *Inpatient*, you or someone acting for you must call your *PCP* or *Tufts Health Plan* within 48 hours after receiving care. Notification from the attending physician satisfies this requirement.)

Information Resources for *Members*

Obtaining information about the *Plan*

The following information about the *Plan* will be available from the Massachusetts Department of Public Health's Office of Patient Protection:

- A list of sources of independently published information assessing member satisfaction and evaluating the quality of health care services offered by the *Plan*.
- The percentage of physicians who voluntarily and involuntarily terminated participation contracts with the *Plan* during the previous calendar year for which such data has been compiled. This information will contain the 3 most common reasons for voluntary and involuntary disenrollment of those physicians.
- The percentage of premium revenue spent by the *Plan* for health care services provided to *Members* for the most recent year for which information is available.
- A report that details the following information for the previous calendar year:
  - the total numbers of filed grievances, grievances denied internally, and grievances withdrawn before resolution; and
  - the total number of external appeals pursued after exhausting the internal grievance process, as well as the resolution of all those external appeals.

How to obtain this information

You can obtain this information about the *Plan* by contacting the Massachusetts Department of Public Health's Office of Patient Protection in the following ways:

- Call 1-800-436-7757
- Write a letter to the Office. Address it to

  Department of Public Health
  Office of Patient Protection
  250 Washington Street, 2nd Floor
  Boston, MA 02108

- Send a fax to the Office. Fax # 1-617-624-5046.
- View information at the Office's Web site. Go to **http://www.state.ma.us/dph/opp/**.

Chapter 2

Eligibility

Introduction This chapter tells you who is eligible, how to apply and when coverage starts.

Eligibility

Eligibility rule

You are eligible as a *Member* only if you meet all of the following criteria, subject to federal law:

- You maintain primary residence in the *Service Area* and live in the *Service Area* for at least 9 months in each period of 12 months.*
- You are eligible for and enrolled in Medicare Parts A and B as either:
  - a person who is age 65 or older; or
  - a person who is disabled, under age 65, and receiving Social Security disability benefits.
- You meet the *Group Insurance Commission's* eligibility rules and regulations, as well as the *Plan's* eligibility rules.

*Note: The 12-month period begins with the first month in which you are not living in the *Service Area*.

Proof of eligibility

The *Plan* may ask you for proof of your eligibility or continuing eligibility. You must provide the *Plan* proof when asked. This may include proof of:

- residence, and
- Medicare Part A and B enrollment.

When to enroll

You may enroll yourself for this coverage only:

- during the annual *Open Enrollment Period*; or
- within 31 days of the date you are first eligible for this coverage.

Effective Date of coverage

If the *Plan* accepts your application and receives the needed *Premium*, coverage starts on the date chosen by the *Group Insurance Commission*.

If you are an *Inpatient* on your *Effective Date*, your coverage starts on the later of:

- the *Effective Date*, or
- the date the *Plan* is notified and given the chance to manage your care.

Chapter 3

Covered Services

Overview

Introduction This chapter describes the health care services and supplies covered under the Tufts Medicare Complement Plan.

In this chapter This chapter contains the following topics.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

***Covered Services*,** Continued

When health care services are *Covered Services*

Health care services and supplies are *Covered Services* only if they are:

- listed as *Covered Services* in this chapter;
- *Medically Necessary*, as determined by the *Plan* and Medicare Parts A and B;
- consistent with applicable state and federal law;
- provided to treat an injury, illness or pregnancy, except for preventive care;
- provided or authorized in advance by your *PCP*, except in an *Emergency* or for *Urgent Care* (see "When You Need *Emergency* or *Urgent Care*" on page 1-17 of this EOC for more information);
- consistent with *Tufts Health Plan's* Clinical Coverage Guidelines in effect at the time the services or supplies are provided. Tufts Health Plan's Clinical Coverage Guidelines are available to you on our Web site at **www.tuftshealthplan.com** or by calling Member Services; and
- in some cases, approved by an *Authorized Reviewer*.
-

IMPORTANT NOTES:

1. If your care is provided or authorized by your *PCP*, the *Plan* will pay:
   - the *Deductibles* and *Coinsurance* for Medicare-eligible services (under Medicare Parts A and B); and
   - the applicable benefit amount for all other *Covered Services*.

   Please see the *Covered Services* tables in Chapter 3 to determine whether you may be required to pay a *Copayment* to the *Plan* for any *Covered Service*.
2. Your care must be provided or authorized by your *PCP*, except for *Emergency* or *Urgent Care*. If it is not, the *Plan* will not cover the costs of any services. Instead, you will be responsible for paying for:
   - any *Deductibles* and *Coinsurance* for Medicare-eligible services (under Medicare Parts A and B; and
   - the full amount of any other services which otherwise would have been covered by the *Plan* under this TMC Plan.

***Authorized Reviewer* approval:** Certain *Covered Services* described in the table below must be authorized in advance by an *Authorized Reviewer*. If such authorization is not received, the *Plan* will not cover those services and supplies.

***Covered Services* table**

Health care services and supplies only qualify as *Covered Services* if they meet the requirements shown above for "When health care services are *Covered Services*". The following table (beginning on page 3-3) describes those services that qualify as *Covered Services*.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

***Covered Services* table (Part A)** The following table describes the *Covered Services* available to you under Medicare Part A of Original Medicare and the Tufts Medicare Complement Plan.

Part A Benefits			
		WHEN CARE AUTHORIZED BY YOUR *PCP**	
BENEFIT	**MEDICARE PAYS…**	**The *Plan* Pays…**	**You Pay…**
Hospital *Inpatient* services provided at a Medicare-certified general hospital: • Semiprivate room (private room if *Medically Necessary*); • Regular nursing services (private duty nursing services are not covered); • *Inpatient* physician services; • Surgery, including the following services in connection with a mastectomy: (1) reconstruction of the breast affected by the mastectomy; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses* and treatment of physical complications of all stages of mastectomy (including lymphedema). *Prosthetic devices are covered as described under "*Durable Medical Equipment*". Removal of breast implants is covered when any of the following conditions exist: (1) the implant was placed post-mastectomy; (2) there is a documented rupture of a silicone implant; or (3) there is documented evidence of auto-immune disease.	Days 1-60 in *Benefit Period*: All *Covered Services*, except the Medicare Part A *Deductible*.	The Medicare Part A *Deductible*.	Nothing.
	Days 61-90 in *Benefit Period*: All covered costs, except the Medicare hospital coinsurance.	The Medicare hospital coinsurance.	Nothing.
	Reserve Days: All *Covered Services*, except the Medicare *Reserve Day* coinsurance, for 60 extra lifetime Medicare *Reserve Days*.	The Medicare *Reserve Day* coinsurance, for 60 extra lifetime *Reserve Days*. After the 60 extra lifetime Medicare *Reserve Days* are exhausted, the *Plan* pays all *Covered Services*.	Nothing for each of the 60 extra lifetime Medicare *Reserve Days*. Also, you pay nothing for all *Covered Services* after the Medicare *Reserve Days* are exhausted.
Note: No coverage is provided for the removal of intact or ruptured saline breast implants or intact saline breast implants except as specified above.			

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Part A Benefits (continued)				
		CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
<u>Hospital *Inpatient* services provided at a Medicare-certified general hospital (continued)</u>: • Use of operating/recovery rooms; • Meals, including special diets; • Drugs and medications furnished by the hospital during your stay; • Laboratory tests; and X-rays and other radiological services; • Medical supplies, such as casts, surgical dressings, and splints; • Cost of special care units, including intensive care and coronary care units; • Rehabilitation services, such as physical therapy, occupational therapy, speech pathology services, nuclear medicine, and kidney dialysis; • Maternity care services (no *PCP* referral required); • Psychiatric and/or psychologist services in a general hospital; • Substance abuse detoxification and rehabilitation services#; and • All other *Medically Necessary* services and supplies.	See page 3-3 above for the amounts paid for these *Covered Services* by Medicare, by you, and by the *Plan*. #If *Inpatient* substance abuse detoxification and rehabilitation services are provided in conjunction with treatment of a *Mental Disorder*, coverage is the same as for "Hospital *Inpatient* Services" at a general hospital (as shown on page 3-3).			

*<u>Note</u>: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Part A Benefits (continued)				
		CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
<u>*Inpatient* blood services</u> The following, provided as part of a covered *Inpatient* stay in a hospital or *Skilled* Nursing Facility: • Whole blood; • Packed red blood cells; • Blood components; and • The cost of blood processing and administration.	All *Covered Services*, **except** for the annual Medicare blood *deductible*. This deductible is for the first 3 pints of unreplaced blood during a calendar year.	The cost of the annual Medicare blood deductible.	Nothing.	The cost of the annual Medicare blood deductible.

*<u>Note</u>: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Part A Benefits (continued)				
		CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
<u>*Skilled* Nursing Facility (SNF) care</u> *Skilled* nursing and rehabilitation services performed by or provided under the supervision of licensed nursing personnel: • Semi-private room; • Nursing services; • Meals, including special diets; • Physical, occupational, and speech therapy; • Drugs and medications furnished by the *skilled* nursing facility during your stay; • Medical supplies, such as casts, surgical dressings, and splints; • Diagnostic services, such as x-rays and laboratory services. <u>Note</u>: *Custodial care* is not covered by either Medicare or the *Plan*.	<u>Days 1 to 20 in a *Benefit Period*</u>: All *Covered Services*.	Nothing.	Nothing.	Nothing.
	<u>Days 21 to 100 in a *Benefit Period*</u>: All *Covered Services*, except for the Medicare SNF *Coinsurance*.	The Medicare SNF *Coinsurance*.	Nothing.	The Medicare SNF *Coinsurance* for each day.
	<u>Days 100+ in a *Benefit Period*</u>: Nothing	Nothing.	All charges after a 100-day SNF stay.	All charges after a 100-day SNF stay.

*<u>Note</u>: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Part A Benefits (continued)				
		CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**

Home Health Care Services:
• Services provided to a homebound *Member* in his/her home by a home health agency:
  • Part-time or intermittent *Skilled* nursing care;
  • Nutritional counseling;
  • Physical therapy; and
  • Speech therapy.
• If you need intermittent *Skilled* nursing care, physical therapy, or speech therapy, Medicare may also pay for:
  • Occupational therapy;
  • Part-time or intermittent services of a home health aide;
  • Medical social services; and
  • Medical supplies and *Durable Medical Equipment* provided by the Home Health Agency.
Note: *Custodial Care* is not covered by either the *Plan* or Medicare.
	For nutritional counseling, physician home visits, and inhalation therapy:
	Nothing
		All *Medically Necessary* charges.	Nothing.	All Charges.

	For *Durable Medical Equipment*: 80% of the Medicare-approved amount.	20% of the Medicare-approved amount.	Nothing.	All Charges.
	For All other Covered Home Health Care Services: All Charges.	Nothing.	Nothing.	Nothing.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Part A Benefits (continued)				
		CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Inpatient Services at a chronic care or Rehabilitation Facility Acute *Inpatient* rehabilitation services provided in an *Inpatient* Rehabilitation Facility. (continued on next page)	Days 1-60 in a *Benefit Period*: All *Covered Services*, except Part A *Deductible*.	The Medicare Part A *Deductible*.	Nothing.	The Medicare Part A *Deductible*.
	Days 61-90 in a *Benefit Period*: All *Covered Services*, except hospital *Coinsurance*.	The Medicare hospital Coinsurance.	Nothing.	The Medicare hospital coinsurance.
	Reserve Days: All *Covered Services*, except Medicare *Reserve Day Coinsurance* for 60 extra lifetime *Reserve Days*.	The Medicare *Reserve Day Coinsurance*, for 60 extra lifetime *Reserve Days*.	Nothing.	The Medicare *Reserve Day Coinsurance*, for 60 extra lifetime *Reserve Days*.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Part A Benefits (continued)				
		CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Inpatient Services at a chronic care or Rehabilitation Facility (continued from previous page)	Additional Days (after you have exhausted Days 1-90 in a *Benefit Period* and your 60 *Reserve Lifetime Days*, as shown on page 3-8): Nothing.	For the remainder of 100 days in a calendar year allowed by the *Plan*: You could incur *Inpatient* days that Medicare pays for either during a covered *Benefit Period* or as *Reserve Days* or excludes because they occur (1) outside of covered *Benefit Period(s)* or (2) after you have exhausted your 60 lifetime *Reserve Days*. If the total number of these days (covered & excluded combined) is less than 100 in a calendar year, the *Plan* will cover any additional days in that year to bring the total to 100 days. The *Plan* will pay all charges for these additional days.	For the remainder of 100 days in a calendar year allowed by the *Plan*: As described in the "The *Plan* Pays" column on this page, you pay nothing for any of the Additional Days that the *Plan* covers in a calendar year. For any days AFTER remainder of 100 days in a calendar year allowed by the *Plan*: You pay all charges for any Additional Days not covered by the *Plan*.	For the remainder of 100 days in a calendar year allowed by the *Plan*: As described in the "the *Plan* Pays" column on this page, you pay all charges for any of the Additional Days that the *Plan* would normally cover in a calendar year. For any days AFTER remainder of 100 days in a calendar year allowed by the *Plan*: In addition, you pay all charges for any Additional Days that the *Plan* would not cover.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Part A Benefits (continued)				
		CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Hospice care for terminally ill *Members* with a life expectancy of 6 months or less: • Home care provided by a hospice program, either a private organization or a public agency, with an emphasis on providing comfort and relief from pain, including: physician services, nursing care, medical appliances and supplies, and physical therapy, occupational therapy and speech therapy services; • Services not ordinarily covered by Medicare, including homemaker services, counseling, and certain prescription drugs# provided for pain or symptom relief; and • *Inpatient* respite care intended to give temporary relief to the person or persons who regularly assist with home care. Covered up to a maximum of 5 consecutive days. #Medicare patients can be charged: a *Copayment* for these prescription drugs; and *Coinsurance* for *Inpatient* respite care.	For each day of Medicare-approved *Inpatient* respite care (maximum of 5 consecutive days) allowed by Medicare: All *Covered Services*, except the coinsurance	The Medicare Part A *Coinsurance*.	Nothing.	The Medicare Part A *Coinsurance*.
	For each covered prescription drug: All *Covered Services*, except the *Copayment*.	The Medicare Part A *Copayment*.	Nothing.	The Medicare Part A *Copayment*.
	For all other *Covered Services*: All *Covered Services*.	Nothing.	Nothing.	Nothing.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

***Covered Services* table (Part B)** The following table describes the *Covered Services* available to you under Medicare Part B of Original Medicare and the Tufts Medicare Complement Plan.

Part B Benefits				
		CARE AUTHORIZED BY YOUR *PCP*		CARE NOT AUTHORIZED BY YOUR *PCP**
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Preventive care services# • A baseline mammogram (for women between the ages of 35 and 40). • Annual mammography screenings (for women age 40 and over). • Annual pap smear, including pelvic exam. Please note that Medicare limits this coverage to one exam every two years, except for annual exam for women: • at high risk for cervical or vaginal cancer, or • of child bearing age who have had a pap smear during the preceding 3 years indicating the presence of cervical or vaginal cancer or other abnormality.	For baseline and annual mammography screenings: 80% of the Medicare-approved amount.	20% of the Medicare-approved amount, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.	All charges after the Medicare payment.
	For Pap Smears (clinical laboratory charge): • Nothing, for exams not covered by Medicare. • All *Covered Services,* for exams covered by Medicare (generally, once every two years). •	• All *Covered Services*, for exams not covered by Medicare (generally, once every two years). • Nothing, for exams covered by Medicare (generally, once every two years). •	• All *Covered Services*, for exams not covered by Medicare (generally, once every two years). • Nothing, for exams covered by Medicare (generally, once every two years).	All Charges after the Medicare payment.

#Additional *Outpatient* preventive care services may be provided (outside of Part B) under this plan. For more information, see the "Other *Covered Services*" benefit later in this "*Covered Services*" section of Chapter 3.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Part B Benefits (continued)				
		CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Preventive care services (continued)# Colorectal cancer screening exam, including: • fecal-occult blood test once every year for persons age 50 and over, • flexible sigmoidoscopy once every four years for persons age 50 and over, and • colonoscopy once every two years for persons at high risk for colorectal cancer.	For the fecal occult blood test: All *Covered Services*.	Nothing.	Nothing.	Nothing.
	For all other tests: 80% of the Medicare-approved amount, except for the annual Medicare Part B *Deductible*.	The annual Medicare Part B *Deductible* and 20% of the Medicare-approved amount, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.	Nothing.
Barium enema – Doctor can substitute for sigmoidoscopy or colonoscopy.	All *Covered Services*.	Nothing.	Nothing.	All charges after the Medicare payment.
Prostate cancer screening (for men age 50 and over) • digital rectal exam, and • PSA test.	For digital rectal exam: 80% of the Medicare-approved amount, except for the annual Medicare Part B *Deductible*.	The annual Medicare Part B *Deductible* and 20% of the Medicare-approved amount, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.	All charges after the Medicare payment.
	For PSA test: All *Covered Services*.	Nothing.	Nothing.	All Nothing.

#Additional *Outpatient* preventive care services may be provided (outside of Part B) under this plan. For more information, see the "Other *Covered Services*" benefit later in this "*Covered Services*" section of Chapter 3.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Part B Benefits (continued)				
		CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Preventive care services (continued)# Vaccinations: • flu shot (1 per year); • pnemonia shot; and Hepatitis B shot for *Members* at medium to high risk for hepatitis.	For flu and pnemonia shots: All *Covered Services*.	Nothing.	Nothing.	Nothing.
	For Hepatitis B shots: 80% of the Medicare-approved amount, except for the annual Medicare Part B *Deductible*.	For Hepatitis B shots: The annual Medicare Part B *Deductible* and 20% of the Medicare Medicare-approved amount. Note: A $10 *Copayment* applies if provided in conjunction with an office visit.	Nothing. Note: A $10 *Copayment* applies if provided in conjunction with an office visit.	All charges after the Medicare payment.
Bone mass measurement for *Members* at risk for losing bone mass.	For bone mass measurement: 80% of the Medicare-approved amount, except for the annual Medicare Part B *Deductible*.	The annual Medicare Part B *Deductible* and 20% of the Medicare-approved amount, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.	All charges after the Medicare payment.

#Additional *Outpatient* preventive care services may be provided (outside of Part B) under this plan. For more information, see the "Other *Covered Services*" benefit later in this "*Covered Services*" section of Chapter 3.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Part B Benefits (continued)				
		CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Emergency room care#: *Medically Necessary Emergency* services obtained in a hospital emergency room **in the United States**. (no *PCP* referral required)	80% of Medicare-approved *Covered Services*, except for the annual Medicare Part B *Deductible*.	The annual Medicare Part B *Deductible* and 20% *Coinsurance*, minus a $50 *Copayment* per Emergency Room visit.	A $50 *Copayment* per Emergency Room visit.	All charges after the Medicare payment.
		Notes: • The $50 Emergency Room *Copayment* is waived if admitted as an *Inpatient*. • An Emergency Room *Copayment* may apply if you register in an Emergency Room but leave facility without receiving care.		
Outpatient services: • Office visits; • Consultation by specialists, including obstetrical and gynecological services; • Allergy testing and treatment; • *Outpatient* physical, occupational, and speech therapy (for diagnosis and treatment of speech, hearing, and language disorders); • Medical services and surgery; (continued on next page)	80% of Medicare-approved *Covered Services*, except for the annual Medicare Part B *Deductible*.	The annual Medicare Part B *Deductible* and 20% *Coinsurance*, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.	All charges after the Medicare payment.

#See "Other *Covered Services*" below for information about obtaining Emergency room care **outside of the United States**.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Part B Benefits (continued)				
		CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Outpatient services - continued: • Immunizations; • Diagnostic imaging services, including general imaging (such as x-rays, and ultrasounds) and MRI/MRA, CT/CTA, PET, and nuclear medicine; • Diagnostic laboratory services including, but not limited to, glysolated hemoglobin (A1c) and urinary protein/microalbumin and lipid profiles; • Inhalation and other home health therapies; • Radiation therapy; • Manipulation of the spine to correct a dislocation that can be shown by an x-ray. (continued on next page)	Diagnostic laboratory services: All *Covered Services*.	Nothing.	Nothing.	All charges after the Medicare payment.
	All other *Outpatient* services listed on this page: 80% of Medicare-approved *Covered Services*, except for the annual Medicare Part B *Deductible*.	The annual Medicare Part B *Deductible* and 20% *Coinsurance*, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.	All charges after the Medicare payment.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Part B Benefits (continued)				
		CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Outpatient services – continued: Podiatric services, when Medicare-approved and provided by a doctor of podiatry or surgical chiropody.# #Note: Routine foot care is not covered.	80% of *Covered Services*, except for the annual Medicare Part B *Deductible*.	The annual Medicare Part B *Deductible* and 20% *Coinsurance*, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.	All charges after the Medicare payment.
The following dental services: • Trauma care, reduction of swelling, and pain relief, for damage to sound and natural teeth; • Reduction of dislocations or fractures of the jaw;	80% of *Covered Services*, except for the annual Medicare Part B *Deductible*.	The annual Medicare Part B *Deductible* and 20% *Coinsurance*, minus the following *Copayments*: • $10 per office visit; • $50 per Emergency Room visit	A $10 *Copayment* per office visit OR A $50 *Copayment* per Emergency Room visit.	All charges after the Medicare payment.
Inpatient or ambulatory surgical services for a non-dental medical condition that requires you to be in a hospital when you receive dental care.	80% of *Covered Services*, except for the annual Medicare Part B *Deductible*.	The annual Medicare Part B *Deductible* and 20% *Coinsurance*.	Nothing.	All charges after the Medicare payment.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Part B Benefits (continued)				
		CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**

Physical therapy, occupational therapy, and speech pathology services, when provided:
• in the following facilities:
  • clinic,
  • hospital,
  • rehabilitation facility, or
  • SNF;
• by a home health agency; or
• by an independent practicing therapist.
	80% of *Covered Services*, except for the annual Medicare Part B *Deductible*.	The annual Medicare Part B *Deductible* and 20% *Coinsurance*, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.	All charges after the Medicare payment.

Outpatient blood services • Whole blood; • Packed red blood cells; • Blood components; and • The cost of blood processing and administration.	80% of *Covered Services*, except for the annual Medicare Blood *Deductible* and the annual Medicare Part B *Deductible*.	The annual Medicare Part B *Deductible* and 20% *Coinsurance*, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.	All charges after the Medicare payments.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Part B Benefits (continued)				
		CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
<u>Ambulance services:</u> Transportation between: • your home and a hospital; • your home and a SNF; or • a hospital and a SNF; if: • the ambulance and personnel meet Medicare requirements; and • transportation in any other vehicle could endanger your health.	80% of *Covered Services*, except for the annual Medicare Part B *Deductible*.	The annual Medicare Part B *Deductible* and 20% *Coinsurance*.	Nothing.	All charges after the Medicare payment.
		Important Note: If you are treated by Emergency Medical Technicians (EMTs) or other ambulance staff, but refuse to be transported to the hospital or other medical facility, you will be responsible for the costs of this treatment.		

*<u>Note</u>: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Part B Benefits (continued)				
		GIC Notices to Subscribers		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
<u>*Durable Medical Equipment*</u> <u>(DME):</u> Includes coverage for devices or instruments of a durable nature that: • are reasonable and necessary to sustain a minimum threshold of independent daily living; • are made primarily to serve a medical purpose; • are not useful in the absence of illness or injury; • can withstand repeated use; and • can be used in the home. <u>Note</u>: Includes breast prostheses (including surgical braissiere after a mastectomy).	80% of *Covered Services*, except for the annual Medicare Part B *Deductible*.	The annual Medicare Part B *Deductible* and 20% *Coinsurance*.	Nothing.	All charges after the Medicare payment.
		In order to be eligible for coverage, the equipment must also be the most appropriate available supply or level of service for the *Member* in question considering potential benefits and harms to that individual. Equipment that *Tufts Health Plan* determines to be non-medical in nature and used primarily for non-medical purposes (even though that equipment may have some limited medical use) will not be considered *Durable Medical Equipment* and will not be covered under this benefit.		

*<u>Note</u>: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Part B Benefits (continued)				
		CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Medical supplies: Examples of *Covered Services* are dressings, splints, and casts.	80% of *Covered Services*, except annual Medicare Part B *Deductible*.	The annual Medicare Part B *Deductible* and 20% *Coinsurance*.	Nothing.	All charges after the Medicare payment.
The following equipment for use in diabetes monitoring by Medicare beneficiaries with diabetes: Blood glucose monitors, including voice synthesizers for blood glucose monitors for use by the legally blind; visual magnifying aids; therapeutic/ molded shoes and shoe inserts for a *Member* with severe diabetic foot disorder; blood glucose monitoring strips, and lancets. In addition, coverage is provided for diabetes self-management training.	80% of Medicare-approved *Covered Services*, except for the annual Medicare Part B *Deductible*.	The annual Medicare Part B *Deductible* and 20% *Coinsurance*.	Nothing.	All charges after the Medicare payment.
		Note: *Tufts Health Plan* also pays for the following *Covered Services* to the extent such services and supplies are not otherwise covered by Medicare: • Urine and ketone monitoring strips. See the Prescription Drug Benefit on page 3-42 for more information. • Diabetes self-management. See "Diabetes self-management training and educational services" on page 3-34 for more information.		
Comprehensive *Outpatient* Rehabilitation Facility (CORF): *Outpatient* rehabilitation services provided at a Comprehensive *Outpatient* Rehabilitation Facility (CORF).	80% of *Covered Services*, except annual Medicare Part B *Deductible* (subject to CORF calendar year maximum benefit for combined physical and occupational therapy).	The annual Medicare Part B deductible, and 20% *Coinsurance*, subject to the CORF calendar year maximum benefit.	All charges after the Medicare calendar year CORF maximum benefit.	All charges after the Medicare payment.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Mental health and substance abuse services table The following table describes the mental health and substance abuse services available to you under Medicare Parts A and B of Original Medicare and the Tufts Medicare Complement Plan.

Mental health and substance abuse services (Parts A and B)				
		CARE AUTHORIZED BY YOUR *PCP*		CARE NOT AUTHORIZED BY YOUR *PCP**
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Inpatient mental health and substance abuse services# (Part A): *Inpatient* hospital and physician services for the treatment of a mental condition or substance abuse. (Continued on next page)	In a general hospital: All *Covered Services,* except for the annual Medicare Part A *Deductible*.	The Medicare Part A *Deductible*.	Nothing.	All charges after the Medicare payment.
	Days 1 - 190 (lifetime) in psychiatric hospital: All *Covered Services*, except for the annual Medicare Part A *Deductible*.	The Medicare Part A *Deductible*.	Nothing.	All charges after the Medicare payment.

#The coverage provided for mental health and substance abuse services is the same for any other *Inpatient* hospital service at a general hospital (as shown on page 3-3 above) for (1) *Inpatient* mental health services for *Biologically-based Mental Disorders* and *Rape-related Mental or Emotional Disorders* (see Appendix A for definitions of these terms); and (2) *Inpatient* substance abuse services provided in conjunction with treatment of a *Mental Disorder*.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Mental health and substance abuse services (Parts A and B)				
Benefit	**Medicare Pays…**	**CARE AUTHORIZED BY YOUR *PCP***		**CARE NOT AUTHORIZED BY YOUR *PCP****
		The *Plan* Pays…	**You Pay…**	**You Pay…**
Inpatient mental health and substance abuse services# (Part A) - continued: Note: When provided in a psychiatric facility, Medicare limits these services to 190 lifetime days. This limit does not apply to inpatient services in a general hospital.	Additional Days in psychiatric hospital (after 190 lifetime days exhausted): Nothing.	All *Covered Services* for • Mental health care services for *Mental Disorders*: up to 60 days per calendar year in a general hospital, a mental health hospital, or a substance abuse facility; and • Substance abuse (alcohol and drug) services for Substance-Abuse Related Disorders: up to 30 days per calendar year in a general hospital or substance abuse facility.	All charges after calendar year maximums exhausted for care in a general hospital, a mental health hospital, or a substance abuse facility.	All charges.
		Note: For information about *Covered Services* for intermediate mental health care services for *Mental Disorders* and intermediate substance abuse services for substance abuse-related disorders, see page 3-23.		

#The coverage provided for mental health and substance abuse services is the same for any other *Inpatient* hospital service (as shown on page 3-3 above) for (1) *Inpatient* mental health services for *Biologically-based Mental Disorders* and *Rape-related Mental or Emotional Disorders* (see Appendix A for definitions of these terms); and (2) *Inpatient* substance abuse services provided in conjunction with treatment of a *Mental Disorder*.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Mental health and substance abuse services (Parts A and B) (continued)			
Benefit	**Medicare Pays…**	**CARE AUTHORIZED BY YOUR *PCP***	**CARE NOT AUTHORIZED BY YOUR *PCP** **You Pay…**
Inpatient mental health and substance abuse services# (Part A) - continued		**Note**: To the extent that these services are not otherwise covered by Medicare, *Tufts Health Plan* pays for the following *Covered Services* for intermediate mental health care services for *Mental Disorders* and intermediate substance abuse (alcohol and drug) services for substance abuse-related disorders: **Intermediate mental health care services for *Mental Disorders*** (These services must be provided or authorized by *Tufts Health Plan*.) These services are more intensive than traditional *Outpatient* mental health care services, but less intensive than 24-hour hospitalization. Some examples of Covered intermediate mental health care services are: level III community-based detoxification; intensive *Outpatient* programs; crisis stabilization; acute residential treatment (longer term residential treatment is not covered); and day treatment/partial hospital programs**. **Two mental health day treatment/partial hospital days count as one of the 60 *Inpatient* days you get per calendar year. **Intermediate substance abuse (alcohol and drug) services for substance abuse-related disorders***** (These services must be provided or authorized by *Tufts Health Plan*.) These services are more intensive than traditional *Outpatient* substance abuse services, but less intensive than 24-hour hospitalization. Some examples of Covered intermediate substance abuse services are day treatment/partial hospital programs and intensive *Outpatient* programs. ***Two substance abuse day treatment/ partial hospital days count as one of the 30 days *Inpatient* days you get per calendar year.	All charges.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Mental health and substance abuse services (Parts A and B) (continued)				
		CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY *PCP****
Benefit	**Medicare Pays…**	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Outpatient mental health and substance abuse services# (Part B): *Outpatient* services for the diagnosis and treatment of a mental condition or substance abuse. Note: Psychopharmacological services and neuropsychological services are covered as "*Outpatient* Services" under Part B (as shown on pages 3-14 and 3-15 above.)	50% of *Covered Services*, except for the annual Medicare Part B *Deductible*.	The annual Medicare Part B *Deductible*, and 50% *Coinsurance*, minus a $10 Copayment per visit.	A $10 Copayment per visit.	All charges after the Medicare payment.

Coverage is provided the same as for *Outpatient* Services" under Part B (as shown on pages 3-14 and 3-15 above) for:

- *Outpatient* mental health services for *Biologically-based Mental Disorders* and *Rape-related Mental or Emotional Disorders* (see Appendix A for definitions of these terms); and
- *Outpatient* substance abuse services provided in conjunction with treatment of a *Mental Disorder*.
- Prior authorization is required for psychological testing and neuropsychological assessment services.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other Covered Services table The following table describes the services which the *Plan* covers, but Original Medicare may not cover. The *Plan* is required under Massachusetts law to cover some of these services.

Other *Covered Services* (outside of Medicare Parts A and B)			
	CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY *PCP****
Benefit	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Preventive care services: • Routine physical exams, including appropriate immunizations and lab tests as recommended by the physician; • routine annual eye exam (no *PCP* referral required); • hearing exams and screenings; and • hormone replacement therapy services.	All *Covered Services*, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.	All charges.
Emergency room care#: *Medically Necessary Emergency* services obtained in a hospital Emergency room **outside of the United States** (no *PCP* referral required).	All *Covered Services*, minus a $50 *Copayment* per Emergency Room visit.	A $50 *Copayment* per Emergency Room visit.	The *Plan* pays for all *Covered Services*, minus a $50 *Copayment* per Emergency Room visit.
	Notes: • The Emergency room *Copayment* is waived if you are admitted as an *Inpatient*. • An Emergency room *Copayment* may apply if you register in an Emergency room but leave that facility without receiving care.		

#See "Part B Benefits" above for information about obtaining Emergency room care **within the United States**.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued			
	CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Coverage is provided as described in this section for *Outpatient* contraceptive services, including consultations, examinations, procedures and medical services, which are related to the use of all contraceptive methods that have been approved by the United States Food and Drug Administration. <u>Family planning:</u> Services: • medical examinations; • consultations; • birth control counseling; and • genetic counseling.	All *Covered Services*, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.	All charges.

*<u>Note</u>: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued			
	CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Family Planning, continued Procedures: • sterilization; and • pregnancy termination.	Office Visit: All *Covered Services*, minus a $10 *Copayment* per visit.	Office Visit: A $10 *Copayment* per visit.	All charges.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued			
	CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Family Planning, continued Contraceptives: • cervical caps; • Intrauterine Devices (IUDs); • implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants); • Depo-Provera or its generic equivalent; • any other ***Medically Necessary*** contraceptive device that has been approved by the United States Food and Drug Administration*. *Note: Please note that *Tufts Health Plan* covers certain contraceptives, such as oral contraceptives and diaphragms, under your Prescription Drug Benefit. For more information, see that benefit on page 3-42.	All *Covered Services*, minus a $10 *Copayment* per visit.	A $10 *Copayment* per visit.	All charges.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued			
	CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Cardiac rehabilitation: Services for *Outpatient* treatment of documented cardiovascular disease that: (1) meet the standards promulgated by the Massachusetts Commissioner of Public Health; and (2) are initiated within 26 weeks after diagnosis of cardiovascular disease. The *Plan* covers only the following services: • the *Outpatient* convalescent phase of the rehabilitation program following hospital discharge; and • the *Outpatient* phase of the program that addresses multiple risk reduction, adjustment to illness and therapeutic exercise. Note: The *Plan* does not cover the program phase that maintains rehabilitated cardiovascular health.	All *Covered Services*.	Nothing.	All charges.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued			
	CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Coronary Artery Disease Program: Coronary Artery Disease secondary prevention program. This program is designed to assist you in making necessary lifestyle changes that can reduce your cardiac risk factors. Note: This benefit is available at designated programs when *Medically Necessary* to *Members* with documented Coronary Artery Disease who meet the clinical criteria established for this program. For more information about this program, *Members* should call a Member Services Coordinator at 1-800-870-9488.	All *Covered Services*, except for 10% *Coinsurance*.	10% *Coinsurance*.	All charges.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued			
	CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
<u>Hemodialysis:</u> The *Plan* covers the following hemodialysis services and supplies, when *Medically Necessary* and provided on an *Outpatient* basis: (1) Services, equipment, and supplies necessary to perform dialysis; (2) Routine dialysis monitoring, lab, and other tests; and (3) Installation and maintenance of a dialyzer of deonizer. <u>Important Notes</u>: • *Outpatient* Services will qualify as *Covered Services* only if they are provided at a *Plan Provider* or other *Plan*-designated facility. • Services provided at the *Member's* home will qualify as *Covered Services* only if they are provided by a *Plan*-designated vendor and when authorized by a *Plan* Physician.	<u>Covered *Outpatient* Services for Items (1) and (2) described in this benefit</u>: All Covered Services.	Nothing.	All charges.
	<u>Covered *Home Services* for Items (1) and (2):</u> All Covered Services.	Nothing.	All charges.
	<u>Covered *Home Services* for Item (3):</u> • The first $300 of *Covered Services*; and • 50% of the Reasonable Charge for any additional Covered Services.	• Nothing for the first $300 of *Covered Services*; and • 50% of the Reasonable Charge for any additional Covered Services.	All charges.

*<u>Note</u>: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued			
	CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Bone marrow transplants for breast cancer (must be approved by an *Authorized Reviewer*): Bone marrow transplants for ***Members*** diagnosed with breast cancer that has progressed to metastatic disease who meet the criteria established by the Massachusetts Department of Public Health.	All *Covered Services*.	Nothing.	All charges.
Nonprescription enteral formulas: Coverage is provided: • For home use for treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, and chronic intestinal pseudo-obstruction. • When *Medically Necessary*: infant formula for milk or soy protein intolerance; formula for premature infants; and supplemental formulas for growth failure.	All *Covered Services*.	Nothing.	All charges.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued			
	CARE AUTHORIZED BY YOUR *PCP*		**CARE NOT AUTHORIZED BY YOUR *PCP****
Benefit	**The *Plan* Pays…**	**You Pay…**	**You Pay…**
Human Leukocyte Antigen Testing: Human leukocyte antigen testing or histocompatibility locus antigen testing for use in bone marrow transplantation when necessary to establish a *Member's* bone marrow transplant donor suitability. Includes: costs of testing for A, B or DR antigens; or any combination consistent with the rules and criteria established by the Department of Public Health.	All *Covered Services*. .	Nothing.	All charges.
Low Protein Foods: When given to treat inherited diseases of amino acids and organic acids.	All *Covered Services,* up to a maximum benefit of $2,500 per calendar year.	All *Covered Services*, **after** the $2,500 calendar year maximum benefit has been reached.	All charges.
Special Medical Formulas: When *Medically Necessary* to protect the unborn fetuses of women with PKU. (Prior approval by an *Authorized Reviewer* may be required.)	All *Covered Services*.	Nothing.	All charges.
Hearing Aids: Hearing aids (including fittings) are covered when *Medically Necessary* and prescribed by a physician. The *Plan* will only cover up to $1,700 per *Member* in a 24-month period.	100% of the first $500. Then, 80% of the next $1,500. Maximum benefit of $1,700 in a 24-month period.	The remaining 20% of the $1,500 amount (after *Plan* pays 80%), plus any additional cost above $1,700 in a 24-month period.	All charges.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued			
Benefit	**CARE AUTHORIZED BY YOUR *PCP***		**CARE NOT AUTHORIZED BY YOUR *PCP****
	The *Plan* Pays…	**You Pay…**	**You Pay…**
Medical Supplies: The *Plan* covers the cost of certain types of medical supplies from an authorized vendor, including: ostomy, tracheostomy, catheter, and oxygen supplies; and insulin pumps and related supplies. These supplies must be obtained from a vendor that has an agreement with *Tufts Health Plan* to provide such supplies.	All *Covered Services*.	Nothing.	All charges.
Diabetes self-management and educational training services: *Outpatient* self-management training and educational services, including medical nutrition therapy, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. **Important Note**: *Tufts Health Plan* will only cover these services when provided by a *Plan Provider* who is a certified diabetes health care provider.	All *Covered Services,* minus a $10 *Copayment* per visit. .	A $10 *Copayment* per visit.	All charges.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued			
Benefit	**CARE AUTHORIZED BY YOUR *PCP***		**CARE NOT AUTHORIZED BY YOUR *PCP****
	The *Plan* Pays…	**You Pay…**	**You Pay…**
Scalp hair prostheses or wigs for cancer or leukemia patients: Scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia.	All *Covered Services*, up to a maximum benefit of $350 per calendar year.	For all services **after** the $350 calendar year maximum benefit has been reached.	All charges.
Patient care services provided as part of a qualified clinical trial for the treatment of cancer: As required by Massachusetts law, patient care services provided pursuant to a qualified clinical trial for the treatment of cancer to the same extent as those *Inpatient* or *Outpatient* services would be covered if the ***Member*** did not receive care in a qualified clinical trial.	*Inpatient* care: All *Covered Services.* *Outpatient* care: All *Covered Services*, minus a $10 *Copayment* per visit.	*Inpatient* care: Nothing. *Outpatient* care: A $10 *Copayment* per visit.	All charges.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued

PRESCRIPTION DRUGS COVERED BY MEDICARE PARTS A AND B

Prescription Drugs Covered By Medicare: Medicare provides coverage for certain prescription drugs used to treat certain medical conditions, including certain injectable medications, when those drugs are obtained and administered by a physician. The physician will bill Medicare, and if the drug meets Medicare's coverage guideline, Medicare will pay for 80% of the Medicare approved charge for that drug. Then, this TMC plan will pay the remainder of the Medicare approved amount for the drug.

Note: Infused medications and their administration are not covered in the home setting (home infusion) under this TMC plan, unless Medicare covers the infused medication and/or its administration as the primary payor. *Tufts Health Plan* will cover any remainder of the cost up to the Medicare allowed amount. *Medically Necessary* hypodermic needles and syringes required to inject these medications are also covered under this section of the Prescription Drug Benefit.

For more information about coverage under this TMC plan, call Member Services at 1-800-870-9488.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued

COVERAGE FOR OTHER PRESCRIPTION DRUGS

Introduction: This section of the Prescription Drug Benefit describes coverage for other prescription drugs under this TMC plan, including certain injectable drugs not covered by Medicare. The following topics are included in this section to explain this prescription drug coverage: "How Prescription Drugs Are Covered"; "Prescription Drug Coverage Table"; "What is Covered"; "What is Not Covered"; "Pharmacy Management Programs"; and "Filling Your Prescription". *Medically Necessary* hypodermic needles and syringes required to inject these medications are also covered under this section of the Prescription Drug Benefit.

Capitalized words are defined in the Glossary in Appendix A.

How Prescription Drugs Are Covered: Prescription drugs will be considered *Covered Services* only if they comply with the Pharmacy Management Programs section described below and are: listed below under "What is Covered"; provided to treat an injury, illness, or pregnancy; *Medically Necessary*; and written by a *Plan* participating physician, except in cases of authorized referral or in Emergencies.

For a current list of covered drugs, please go to the *Plan's* Web site at **www.tuftshealthplan.com,** or call Member Services at 1-800-870-9488.

For a list of non-covered drugs, please see Appendix B.

The Prescription Drug Coverage Table below describes your prescription drug benefit amounts.

- Tier-1 drugs have the lowest *Copayment*; many generic drugs are on Tier-1.
- Tier-2 drugs have the middle *Copayment*.
- Tier-3 drugs have the highest *Copayment*.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued

Where to fill prescriptions: You can fill your prescriptions at any *Plan* designated pharmacy. *Plan* designated pharmacies include:

- for the majority of prescriptions, most of the pharmacies in Massachusetts and additional pharmacies nationwide; and
- for a select number of drug products, a small number of special designated pharmacy providers. (For more information about *Tufts Health Plan's* special designated pharmacy program, see "Pharmacy Management Programs" earlier in this Prescription Drug Benefit section.) If you have questions about where to fill your prescription, call Member Services Department at 1-800-870-9488.

How to fill prescriptions:

- Make sure the prescription is written by a *Plan* participating physician, except in cases of authorized referral or in Emergencies.
- When you fill a prescription, provide your Member ID card to any *Plan* designated pharmacy.
- If the retail cost of your prescription is less than your *Copayment*, then you are responsible for the actual retail cost.
- If you have any problems using this benefit at a *Plan* designated pharmacy, call Member Services at 1-800-870-9488.

Important: Your prescription drug benefit is honored only at *Plan* designated pharmacies. In cases of *Emergency*, please call Member Services at 1-800-870-9488 for instructions about submitting your prescription drug claims for reimbursement.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued

Filling Prescriptions for Maintenance Medications:

If you are required to take a maintenance medication, the *Plan* offers you two choices for filling your prescription medications:

- you may obtain your maintenance medication directly from a *Plan* designated retail pharmacy; or
- you may have most maintenance medications mailed to you through a *Plan* designated mail services pharmacy.

The following may not be available to you through a *Plan* designated mail services pharmacy:

- medications for short term medical conditions;
- certain controlled substances and other prescribed drugs that may be subject to exclusions or restrictions;
- medications that are part of the *Plan's* Dispensing Limitations program; or
- medications that are part of the *Plan's* Special Designated Pharmacy program.

Note: Your *Copayments* for maintenance medications are shown in the Prescription Drug Coverage Table below.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued			
PRESCRIPTION DRUG COVERAGE TABLE			
	PRESCRIPTION DRUGS THAT…		
	QUALIFY AS *COVERED SERVICES*, AS DESCRIBED BELOW.		**DO NOT QUALIFY AS *COVERED SERVICES*, AS DESCRIBED BELOW.**
Benefit	***Tufts HP* Pays…**	**You Pay…**	**You Pay…**
Prescription Drug Benefit, as described below.	All *Covered Services*, except for the applicable *Copayment* below.	The applicable *Copayment* shown below for covered prescription drugs.	All charges.
Benefit Description	**Coverage**		
DRUGS OBTAINED AT A RETAIL PHARMACY: Covered prescription drugs (including both acute and maintenance drugs), when you obtain them directly from a *Tufts HP* designated retail pharmacy.	**<u>Tier-1 drugs</u>**: • $8 *Copayment* for up to 30-day supply • $16 *Copayment* for a 31-60 day supply • $24 *Copayment* for a 61-90 day supply **<u>Tier-2 drugs</u>:** • $20 *Copayment* for up to 30-day supply • $40 *Copayment* for a 31-60 day supply • $60 *Copayment* for a 61-90 day supply **<u>Tier-3 drugs</u>:** • $35 *Copayment* for up to 30-day supply • $70 *Copayment* for a 31-60 day supply • $105 *Copayment* for a 61-90 day supply		**Notes:** • If you fill your prescription in a state that allows you to request a brand-name drug even though your physician authorizes the generic equivalent, you will pay the applicable Tier *Copayment* <u>plus</u> the difference in cost between the brand-name drug and the generic drug. • You always pay the applicable *Copayment*, even if the cost of the drug is less than the *Copayment*.

*<u>Note</u>: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued	
COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued	
PRESCRIPTION DRUG COVERAGE TABLE - continued	
Benefit Description	**Coverage**
DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY: Most maintenance medications, when mailed to you through a *Tufts HP* designated mail services pharmacy.	**Tier-1 drugs**: $16 *Copayment* for up to a 90-day supply **Tier-2 drugs:** $40 *Copayment* for up to a 90-day supply **Tier-3 drugs:** $70 *Copayment* for up to a 90-day supply

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued

What Is Covered:

The *Plan* covers the following under this Prescription Drug Benefit:

- Prescribed drugs (including hormone replacement therapy for peri and post-menopausal women) that by law require a prescription and are not listed under "What is Not Covered" (see "Important Notes" below).
- Insulin, insulin pens, insulin needles and syringes; oral diabetes medications that influence blood sugar levels; and urine glucose and ketone monitoring strips. Please see Part B – Benefits (page 3-20) for more information about coverage for lancets and blood glucose strips, when provided by your Medicare Benefit instead of this Prescription Drug Benefit under your TMC plan;
- Acne medications for individuals through the age of 25;
- Oral contraceptives, diaphragms, Depo-Provera, and other hormonal contraceptives (e.g., patches, rings) that by law require a prescription#;

  # Note: This Prescription Drug Benefit only describes coverage for oral contraceptives, diaphragms, Depo-Provera, and other hormonal contraceptives (e.g., patches, rings) that by law require a prescription. See "Family Planning" on page 3-28 for information about other contraceptive drugs and devices that qualify as *Covered Services*. Also note that, in certain circumstances, Depo-Provera may qualify as a *Covered Service* under the "Family planning" benefit.
- Prefilled sodium chloride for inhalation (both prescription and over-the-counter).
- Off-label use of FDA-approved prescription drugs used in the treatment of cancer or HIV/AIDS which have not been approved by the FDA for that indication, provided, however, that such a drug is recognized for such treatment:
  - in one of the standard reference compendia;
  - in the medical literature; or
  - by the commissioner of insurance.
- Compounded medications, if at least one active ingredient requires a prescription by law.

Note: Certain prescription drugs products may be subject to one of the Pharmacy Management Programs described below.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued

What Is Not Covered:

The *Plan* does not cover the following under this Prescription Drug Benefit:

- Prescription and over-the-counter homeopathic medications.
- Drugs that by law do not require a prescription (unless listed as covered in the "What is Covered" section above).
- Drugs that are listed in Appendix B ("Non-Covered Drugs with Suggested Alternatives") at the end of this Evidence of Coverage.
- Vitamins and dietary supplements (except prescription prenatal vitamins).
- Topical and oral fluorides for adults.
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants), Depo-Provera (these are covered under your *Outpatient* care benefit on page 3-28 in this chapter),
- Medications for the treatment of idiopathic short stature.
- Experimental drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Non-drug products such as therapeutic or other prosthetic devices, appliances, supports, or other non-medical products. These may be provided as described on pages 3-3, 3-19, and 3-20 in this chapter.
- Immunization agents. These may be provided under Preventive health care on page 3-11 in this chapter.
- Prescriptions written by physicians who do not participate in the *Plan*, except in cases of authorized referral or *Emergency* care.
- Prescriptions filled at pharmacies other than *Plan* designated pharmacies, except for *Emergency* care.
- Smoking cessation agents.
- Drugs for asymptomatic onchomycosis, except for *Members* with diabetes, vascular compromise, or immune deficiency status.
- Acne medications for individuals 26 years of age or older, unless *Medically Necessary*.
- Drugs which are dispensed in an amount or dosage that exceeds the *Plan's* established dispensing limitations.
- Compounded medications, if no active ingredients require a prescription by law.
- Prescriptions filled through an internet pharmacy that is not a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- Prescription medications once they become available over-the-counter. In this case, the specific medication may not be covered and the entire class of prescription medications may also not be covered.
- Prescription medications when packaged with non-prescription products.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Other *Covered Services* (outside of Medicare Parts A and B) - continued

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued

Pharmacy Management Programs:

In order to provide safe, clinically appropriate, cost-effective medications under this Prescription Drug Benefit, the *Plan* has developed the following Pharmacy Programs and Initiatives:

Dispensing Limitations Program:

The *Plan* limits the quantity of selected medications that *Members* can receive in a given time period, for cost, safety and/or clinical reasons.

Prior Authorization Program:

The *Plan* restricts the coverage of certain drug products that have a narrow indication for usage, may have safety concerns and/or are extremely expensive, requiring the prescribing physician to obtain prior approval from the *Plan* for such drugs.

Special Designated Pharmacy Program (Mail Order):

The *Plan* has designated special pharmacies to supply a select number of medications via mail order including medications used in the treatment of infertility, multiple sclerosis, hemophilia, hepatitis C; growth hormone deficiency, rheumatoid arthritis, and cancers treated with oral medications. These pharmacies specialize in providing medications used to treat certain conditions, and are staffed with clinicians to provide support services for *Members*. Medications may be added to this program from time to time. Special pharmacies can dispense up to a 30-day supply of medication at one time via mail order.

Non-Covered Drugs with Suggested Alternatives:

While the *Plan* covers over 4,500 drugs, a small number of drugs (less than 1%) are not covered because there are safe, effective and more affordable alternatives available. These non-covered drugs are listed in Appendix B. All of the alternative drug products are approved by the U.S. Food and Drug Administration (FDA) and are widely used and accepted in the medical community to treat the same conditions as the medications that are no longer covered.

New-To-Market Drug Evaluation Process:

The *Plan's* Pharmacy and Therapeutics Committee reviews new-to-market drug products for safety, clinical effectiveness and cost. The *Plan* then makes a coverage determination. based on the Pharmacy and Therapeutics Committee's recommendation. A new drug product will not be covered until this process is completed – usually within 6 months of the drug product's availability.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Pharmacy Programs and Initiatives, continued

IMPORTANT NOTES:

- If your physician feels it is *Medically Necessary* for you to take medications that are restricted under any of the Pharmacy Management Programs described above, he or she may submit a request for coverage. The *Plan* will approve the request if it meets our guidelines for coverage. For more information, you can call Member Services at 1-800-870-9488.
- The *Plan's* Web site has a list of covered drugs with their tiers. The *Plan* may change a drug's tier during the year. For example, if a brand drug's patent expires, the *Plan* may change the drug's status by either (a) moving the brand drug from tier 2 to tier 3 or (b) moving the brand drug to our list of non-covered drugs in Appendix C when the generic drug becomes available. Many generic drugs are available on tier 1.
- If you have questions about your prescription drug benefit, would like to know the tier of a particular drug, or would like to know if your medication is part of a Pharmacy Management Program, check the *Plan's* Web site at **www.tuftshealthplan.com**, or call Member Services at 1-800-870-9488.

*Note: When care is not provided or authorized by your *PCP,* the *Plan* does not pay for any services or supplies other than *Medically Necessary* Emergency services (as described on pages 3-14 and 3-25).

Exclusions from Benefits

List of exclusions

The *Plan* will not pay for the following services, supplies, or medications:

- A service, supply or medication which is not *Medically Necessary*.
- A service, supply or medication which is not a *Covered Service*.
- A service, supply or medication received outside the *Service Area*, except as described under “How the Plan Works” in Chapter 1.
- A service, supply or medication that is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
- A service, supply, or medication if there is a less intensive level of service supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting.
- A service, supply, or medication that is primarily for your, or another person’s, personal comfort or convenience.
- *Custodial Care*.
- Services related to non-covered services.
- A drug, device, medical treatment or procedure (collectively "treatment") that is *Experimental or Investigative*.

  This exclusion does not apply to:
  - bone marrow transplants for breast cancer;
  - patient care services provided pursuant to a qualified clinical trial; or
  - off-label uses of prescription drugs for the treatment of cancer or HIV/AIDS;

  which meet the requirements of Massachusetts law.

  If the treatment is *Experimental or Investigative*, the *Plan* will not pay for any related treatments which are provided to the *Member* for the purpose of furnishing the *Experimental or Investigative* treatment.
- Drugs, medicines, materials or supplies for use outside the hospital or any other facility, except as described in a Prescription Drug Benefit (see pages 3-36 through 3-45). Medications and other products which can be purchased without a prescription except those listed as covered under the Prescription Drug Benefit.
- Injectable medications, except as described on pages 3-36 and 3-37.
- Infused medications and their administration are not covered in the home setting (home infusion) under this TMC plan, unless Medicare covers the infused medication and/or its administration as the primary payor. *Tufts Health Plan* will cover any remainder of the cost up to the Medicare allowed amount.

List of exclusions (continued)

- Services provided by your relative (by blood or marriage) unless the relative is a *Plan Provider* and the services are authorized by your *PCP*. If you are a *Plan Provider*, you cannot provide or authorize services for yourself or be your own *PCP* for yourself or a member of your immediate family (by blood or marriage).
- Services, supplies, or medications required by a third party which are not otherwise *Medically Necessary*. Examples of a third party are: employer; insurance company; school; or court.
- Services for which you are not legally obligated to pay or services for which no charge would be made if you had no health plan.
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.
- Any additional fee a *Provider* may charge as a condition of access or any amenities that access fee is represented to cover. Refer to the *Directory of Health Care Providers* to determine if your *Provider* charges such a fee.
- Facility charges or related services if the procedure being performed is not a *Covered Service*.
- Preventive dental care; periodontal treatment; orthodontics; dental supplies; dentures; restorative services including, but not limited to, crowns, fillings, root canals, and bondings; skeletal jaw surgery, except as provided under “dental services” on page 3-16; alteration of teeth; care related to deciduous (baby) teeth; splints and oral appliances (except for sleep apnea), including those for TMJ disorders.
- Surgical removal or extraction of teeth, except as provided under “dental services” on page 3-16.
- Cosmetic (meaning to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided on page 3-3. Breast reconstruction is covered when following a *Medically Necessary* mastectomy, as described in “Hospital *Inpatient* Services (Part A) on page 3-3.
- Rhinoplasty; liposuction; and brachioplasty.
- Treatment of spider veins; removal or destruction of skin tags; treatment of vitiligo.

List of exclusions (continued)

- Hair removal, except when *Medically Necessary* to treat an underlying skin condition.
- Costs associated with home births.
- Infertility services, infertility medications, and associated reproductive technologies (such as IVF, GIFT, and ZIFT) including, but not limited to, experimental infertility procedures; the costs of surrogacy; reversal of voluntary sterilization; sperm or embryo cryopreservation; donor recruitment fee for donor egg or donor sperm; donor sperm and associated laboratory services, costs associated with donor recruitment and compensation; and Infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization.
- Preimplantation genetic testing and related procedures performed on gametes or embryos.
- Treatments, medications, procedures, services and supplies related to: medical or surgical procedures for sexual reassignment; reversal of voluntary sterilization; or over-the-counter contraceptive agents.
- Human organ transplants, except as provided under federal Medicare guidelines.
- Services provided to a non-*Member*:
- Acupuncture; biofeedback, except for the treatment of urinary incontinence; hypnotherapy; psychoanalysis; TENS units or other neuromuscular stimulators and related supplies; electrolysis; any type of thermal therapy device; *Inpatient* and *Outpatient* weight-loss programs and clinics; exercise classes; relaxation therapies; massage therapies, except when provided as covered physical therapy services; services by a personal trainer; exercise classes; cognitive rehabilitation programs; cognitive retraining programs. Also excluded are diagnostic services related to any of these procedures or programs.
- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.
- All alternative, holistic, naturopathic, and/or functional health medicine services, supplies, or procedures, and all services, procedures, labs and supplements associated with this type of medicine.
- Any service, supply, or procedure performed in a non-conventional setting (including, but not limited to, spas/resorts, therapeutic programs, and camps).

List of exclusions (continued)

- Blood, blood donor fees, blood storage fees, or blood substitutes; blood banking, cord blood banking and blood products, except as detailed in the "Note" below.

  Note: The following blood services and products are covered:

  - blood processing;
  - blood administration;
  - Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease (prior approval by an *Authorized Reviewer* is required);
  - intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (prior approval by an *Authorized Reviewer* is required).

- Examinations, evaluations or services for educational or developmental purposes, including physical therapy, speech therapy, and occupational therapy, except as provided on page 3-17. Vocational rehabilitation services and vocational retraining. Also services to treat learning disabilities, behavioral problems, and developmental delays and services to treat speech, hearing and language disorders in a school-based setting. The term “developmental” refers to a delay in the expected achievement of age-appropriate fine motor, gross motor, social, or language milestones that is not caused by an underlying medical illness or condition.

- Eyeglasses, lenses or frames; or refractive eye surgery (including radial keratotomy) for conditions which can be corrected by means other than surgery. The *Plan* will not pay for contact lenses or contact lens fittings.

- Methadone treatment or methadone maintenance.

- Routine foot care, such as: trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet. This exclusion does not apply to routine foot care for *Members* diagnosed with diabetes.

  Note: This exclusion does not apply to therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the *Member’s* treating doctor, and the shoes and inserts:

  - are prescribed by a *Provider* who is a podiatrist or other qualified doctor; and
  - are furnished by a *Provider* who is a podiatrist, orthotist, prosthetist, or pedorthist.

- Transportation, including transportation by chair car, wheelchair van, or taxi, except as described in “Ambulance Services” in this Chapter; lodging related to receiving any medical service.

Chapter 4
When Coverage Ends

Overview

Introduction

This chapter tells you when coverage ends.

Reasons coverage ends

Coverage ends when any of the following occurs:

- you lose eligibility because you
  - no longer meet the *Group Insurance Commission's* or the *Plan's* eligibility rules,
  - no longer are eligible for and enrolled in Parts A and B of Medicare (please refer to your Medicare Handbook for events that can change your Medicare coverage), or
  - move out of the *Service Area**,
- you choose to drop coverage,
- you commit an act of physical or verbal abuse unrelated to your physical or mental condition which poses a threat to: any *Provider*; any *Member*; or the *Plan* or any *Plan* employee,
- misrepresentation or fraud, or
- the *Group Insurance Commission's* Contract with the *Plan* ends.

*Note: For more information about coverage when you move out of the *Service Area*, please contact the *Group Insurance Commission* at 617-727-2310, ext. 1.

Benefits after termination

The *Plan* will not pay for services you receive after your coverage ends even if

- you were receiving *Inpatient* or *Outpatient* care when your coverage ends, or
- you had a medical condition (known or unknown), including pregnancy, that requires medical care after your coverage ends.

When a *Member* is No Longer Eligible

Loss of eligibility

Your coverage ends on the date you

- no longer meet the *Group Insurance Commission's* or the *Plan's* eligibility rules, or
- no longer are eligible for and enrolled in Parts A and B of Medicare.

> **Important Note:** Your coverage will terminate retroactively to the date you are no longer eligible for coverage.

If you move out of *the Service Area*

If you move out of the *Service Area*, coverage ends the last day of the month in which you move.

Tell the *Group Insurance Commission* or call Member Services before you move to notify the *Plan* of the date you are moving. If you keep a residence in the *Service Area* but have been out of the *Service Area* for more than 90 days, coverage ends 90 days after the date you left the *Service Area*.

For more information about coverage available to you when you move out of the *Service Area*, contact Member Services at 1-800-870-9488.

You choose to drop coverage

Coverage ends if you decide you no longer want coverage. To end your coverage, notify the *Group Insurance Commission* at least 30 days before the date you want your coverage to end. You must pay *Premiums* up through the day your coverage ends.

Membership Termination for Acts of Physical or Verbal Abuse

Acts of physical or verbal abuse

The *Plan* may terminate your coverage if you commit acts of physical or verbal abuse which:

- are unrelated to your physical or mental condition;
- pose a threat to:
  - any *Provider*,
  - any *Member*, or
  - the *Plan* or any *Plan* employee.

Membership Termination for Misrepresentation or Fraud

Policy

Tufts Health Plan may terminate your coverage for misrepresentation or fraud. If your coverage is terminated for misrepresentation or fraud, *Tufts HP* may not allow you to re-enroll for coverage with *Tufts HP* under any other plan (such as a Nongroup or another employer's plan) or type of coverage (for example, coverage as a *Spouse*).

Acts of misrepresentation or fraud

Examples of misrepresentation or fraud include:

- false or misleading information on your application;
- enrolling as a *Spouse* someone who is not your *Spouse*;
- receiving benefits for which you are not eligible; or
- allowing someone else to use your Member ID card.

Date of termination

If *Tufts Health Plan* terminates your coverage for misrepresentation or fraud, your coverage will end as of your *Effective Date* or a later date chosen by the *Plan*.

Payment of claims

Tufts Health Plan will pay for all *Covered Services* you received between:

- your *Effective Date*; and
- your termination date, as chosen by the *Plan*. *Tufts Health Plan* may retroactively terminate your coverage back to a date no earlier than your *Effective Date*.

Tufts Health Plan will use any *Premium* you paid for a period after your termination date to pay for any *Covered Services* you received after your termination date.

If the *Premium* is <u>not</u> enough to pay for that care, *Tufts Health Plan*, at its option, may:

- pay the *Provider* for those services and ask you to pay *Tufts Health Plan* back; or
- <u>not</u> pay for those services. In this case, you will have to pay the *Provider* for the services.

If the *Premium* is more than is needed to pay for *Covered Services* you received after your termination date, *Tufts Health Plan* will refund the excess to the *Group Insurance Commission*.

Voluntary and Involuntary Disenrollment Rates for *Members*

Voluntary and Involuntary Disenroll-ment Rates for *Members*

As required by Massachusetts law, the *Plan* conducts an annual disenrollment study. Annually, the study looks at the reasons *Members* leave *Tufts Health Plan*, in order to track voluntary and involuntary disenrollment rates.

- **Voluntary Disenrollment Rate -** The number of *Members* the *Plan* disenrolled because they ceased to pay *Premiums*. This is the voluntary disenrollment rate. For the year 2007, less than one percent of *Members* voluntarily disenrolled by ceasing to pay their *Premiums*.

- **Involuntary Disenrollment Rate -** The number of *Members* that the *Plan* disenrolled because of fraud or acts of physical or verbal abuse. This is the involuntary disenrollment rate. For the year 2007, less than one percent of *Members* were involuntarily disenrolled as a result of fraud or abuse.

For additional information about the voluntary and involuntary disenrollment rates among *Tufts Health Plan Members*, call Member Services at 1-800-870-9488.

Termination of the *Group Contract*

Termination

This topic describes the end of the *Group Contract*.

End of the *relationship between the Plan* and *the Group Insurance Commission*

Coverage will terminate if the relationship between the *Group Insurance Commission* and the *Plan* ends for any reason, including

- the *Group Insurance Commission's* contract with the *Plan* terminates;
- the *Group Insurance Commission* fails to pay *Premiums* on time;
- the *Plan* stops operating; or
- the *Group Insurance Commission* stops operating.

Obtaining a Certificate of Creditable Coverage

The Group Insurance Commission will mail a Certificate of Creditable Coverage will be mailed to each *Subscriber* upon termination in accordance with federal law. You may also obtain a copy of your Certificate of Creditable Coverage by contacting the *GIC* at (617) 727-2310, extension 1.

Chapter 5

Member Satisfaction

Member Satisfaction Process

The *Plan* has a multi-level *Member* Satisfaction process including:

- Internal Inquiry;
- *Member* Grievances Process;
- Internal *Member* Appeals; and
- External Review by the Office of Patient Protection.

All grievances and appeals should be sent to *Tufts HP* at the following address:

Tufts Health Plan
Attn: Appeals and Grievances Dept.
705 Mt. Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193

All calls should be directed to Member Services at **1-800-870-9488**.

Internal Inquiry

Call a Member Services Coordinator to discuss concerns you may have regarding your healthcare. Every effort will be made to resolve your concerns within three (3) business days. If your concerns cannot be resolved within three (3) business days or if you tell a Member Services Coordinator that you are not satisfied with the response you have received from *Tufts HP*, the *Plan* will send you a letter describing any options you may have, including the right to have your inquiry processed as a grievance or appeal. If you choose to file a grievance or appeal, you will receive written acknowledgement and written resolution in accord with the timelines outlined below.

Tufts HP maintains records of each inquiry made by a *Member* or by that *Member's* authorized representative. The records of these inquiries and the response provided by *Tufts HP* are subject to inspection by the Commissioner of Insurance and the Department of Public Health.

Important Note: In many instances, we will ask you to direct your initial concern to Medicare (since Medicare will make the primary determination on your health care benefits). Information is available by contacting your local Social Security office or via the internet on the official Medicare Web site at **www.medicare.gov**.

Member Grievance Process

A grievance is a formal complaint about actions taken by *Tufts HP* or a *Provider*. There are two types of grievances: administrative grievances and clinical grievances. The two types of grievances are described below.

It is important that you contact *Tufts HP* as soon as possible to explain your concern. Call a *Tufts HP* Member Services Coordinator who will document your concern and forward it to a Grievance Analyst in the Appeals and Grievance Department. Grievances may be filed either verbally or in writing. To accurately reflect your concerns, you may want to put your grievance in writing and send it to the address provided at the beginning of this section. Your explanation should include:

- your name and address;
- your Member ID number;
- a detailed description of your concern (including relevant dates, any applicable medical information, and *Provider* names); and
- any supporting documentation.

Important Note: The *Member* Grievance Process does not apply to requests for a review of a denial of coverage. If you are seeking such a review, please see the "Internal *Member* Appeals" section below.

Administrative Grievance Timeline

- If you file your grievance in writing, within five (5) business days after receiving your letter, the *Plan* will notify you by mail that your letter has been received and provide you with the name, address, and telephone number of the Grievance Analyst coordinating the review of your grievance.
- If you file your grievance verbally, within forty-eight (48) hours the *Plan* will send you a written confirmation of our understanding of your concerns. The *Plan* will also include the name, address, and telephone number of the person coordinating the review.
- If your request for review was first addressed through the internal inquiry process, and does not require the review of medical records, the thirty (30) calendar day review period will begin the day following the end of the three (3) business day internal inquiry process or earlier if you notify *Tufts HP* that you are not satisfied with the response you received during the Internal Inquiry process.
- If your grievance requires the review of medical records, you will receive a form that you will need to sign which authorizes your *Providers* to release medical information relevant to your grievance to *Tufts HP*. You must sign and return the form before *Tufts HP* can begin the review process. If you do not sign and return the form to *Tufts HP* within thirty (30) business days of the date you filed, *Tufts HP* may issue a response to your grievance without having reviewed the medical records. You will have access to any medical information and records relevant to your grievance which are in the possession and control of *Tufts HP*.
- *Tufts HP* will review your grievance, and will send you a letter regarding the outcome, as allowed by law, within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended beyond the time allowed by law upon mutual written agreement between you or your authorized representative and *Tufts HP*.

Clinical Grievances

A clinical grievance is a complaint about the quality of care or services that you have received. If you have concerns about your medical care, you should discuss them directly with your *Provider*. If you are not satisfied with your *Provider's* response or do not wish to address your concerns directly with your *Provider*, you may contact Member Services to file a clinical grievance.

If you file your grievance in writing, we will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Grievance Analyst coordinating the review of your grievance. If you file your grievance verbally, we will send you a written confirmation of our understanding of your concerns within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.

Tufts HP will review your grievance and will notify you in writing regarding the outcome, as allowed by law, within thirty (30) calendar days of receipt. The review period may be extended up to an additional thirty (30) days if additional time is needed to complete the review of your concern. You will be notified in writing if the review timeframe is extended.

"Reconsideration"

If you are not satisfied with the result of the Clinical Grievance review process, you may request a "reconsideration". If you so choose, your concerns will be reviewed by a clinician who was not involved in the initial review process. Upon request for a reconsideration, your concerns will be reviewed within thirty (30) calendar days. You will be notified in writing of the results of the review.

Internal *Member* Appeals

An appeal is a request for a review of a denial of coverage for a service or supply that has been reviewed and denied by *Tufts HP* based on medical necessity (an adverse determination) or a denial of coverage for a specifically excluded service or supply. The *Tufts Health Plan* Appeals and Grievances Department will review all of the information submitted upon appeal, taking into consideration your benefits as detailed in this *Evidence of Coverage.*

It is important that you contact *Tufts HP* as soon as possible to explain your concern. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file an internal appeal. Appeals may be filed either verbally or in writing. If you would like to file a verbal appeal, call a Member Services Coordinator who will document your concern and forward it to a Member Appeals Analyst in the Appeals and Grievance Department. To accurately reflect your concerns, you may want to put your appeal in writing and send it to the address provided at the beginning of this section. Your explanation should include:

- your name and address;
- your Member ID number;
- a detailed description of your concern (including relevant dates, any applicable medical information, and *Provider* names); and
- any supporting documentation.

Appeals Timeline

- If you file your appeal in writing, within five (5) business days after receiving your letter, *Tufts Health Plan* will notify you in writing that your letter has been received and provide you with the name, address, and telephone number of the Member Appeals Analyst coordinating the review of your appeal.
- If you file your appeal verbally within forty-eight (48) hours *Tufts Health Plan* will send you a written confirmation of our understanding of your concerns. The *Plan* will also include the name, address, and telephone number of the Member Appeals Analyst coordinating the review of your appeal.
- If your request for review was first addressed through the internal inquiry process, and does not require the review of medical records, the thirty (30) calendar day review period will begin the day following the end of the three (3) day internal inquiry process or earlier if you notify *Tufts HP* that you are not satisfied with the response you received during the internal inquiry process.
- *Tufts HP* will review your appeal, make a decision, and send you a decision letter within 30 calendar days of receipt.
- The time limits in this process may be waived or extended beyond the time allowed by law upon mutual verbal or written agreement between you or your authorized representative and *Tufts HP*.

This extension may be necessary if we are waiting for medical records that are necessary for the review of your appeal and have not received them. The Appeals Analyst handling your case will notify you in advance if an extension may be needed. In addition, a letter will be sent to you confirming the extension.

When Medical Records are Necessary

If your appeal requires the review of medical records you will receive a form that you will need to sign which authorizes your *Providers* to release to *Tufts HP* medical information relevant to your Appeal. You must sign and return the form before *Tufts HP* can begin the review process. If you do not sign and return the form to *Tufts HP* within thirty (30) calendar days of the date you filed your appeal, *Tufts HP* may issue a response to your request without having reviewed the medical records. You will have access to any medical information and records relevant to your appeal, which are in the possession and control of *Tufts HP*.

Who Reviews Appeals?

If the appeal involves a medical necessity determination, an actively practicing physician in the same or similar specialty as typically treats the medical condition, and who did not participate in any of the prior decisions on the case will take part in the review. In addition, a Committee made up of Managers and Clinicians from various *Tufts HP* departments will review your appeal. A Committee within the Appeals and Grievances Department will review appeals involving non-covered services.

Appeal Response Letters

The letter you receive from *Tufts HP* will include identification of the specific information considered for your appeal and an explanation of the basis for the decision. A response letter regarding a final adverse determination (a decision based on medical necessity) will include: the specific information upon which the adverse determination was based; *Tufts HP's* understanding of your presenting symptoms or condition; diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria; alternative treatment options offered, if any; applicable clinical practice guidelines and review criteria; notification of the steps for requesting external review by the Office for Patient Protection; and the titles and credentials of the individuals who reviewed the case. Please note that requests for coverage of services that are specifically excluded in your *Evidence of Coverage* (EOC) are not eligible for external review.

An appeal not properly acted on by *Tufts HP* within the time limits of Massachusetts law and regulations, including any extensions made by mutual written agreement between you or your authorized representative and *Tufts HP*, shall be deemed resolved in your favor.

Expedited Appeals

Tufts HP recognizes that there are circumstances that require a quicker turnaround than the 30 calendar days allotted for the standard Appeals Process. *Tufts HP* will expedite an appeal when there is an ongoing service about to terminate or a service to be delivered imminently whereby a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function. Should you feel that your request meets the criteria cited above, you or your attending physician should contact the Member Services Department. Under these circumstances, you will be notified of *Tufts HP's* decision within seventy-two (72) hours after the review is initiated. If your treating physician (the physician responsible for the treatment or proposed treatment) certifies that the service being requested is Medically Necessary; that a denial of coverage for such services would create a substantial risk of serious harm; and such risk of serious harm is so immediate that the provision of such services should not await the outcome of the normal grievance process, you will be notified of Tufts HP's decision within forty-eight (48) hours of the receipt of certification. If you are appealing coverage for Durable Medical Equipment (DME) that Tufts HP determined was not Medically Necessary, you will be notified of Tufts HP's decision within less than forty-eight (48) hours of the receipt of certification. If you are an *Inpatient* in a hospital, *Tufts HP* will notify you of the decision before you are discharged. If your appeal concerns the termination of ongoing coverage or treatment, the disputed coverage may remain in effect at Tufts HP's expense through the completion of the Internal Appeals Process. Only those services which were originally authorized by Tufts Health Plan and which were not terminated pursuant to a specific time or episode-related exclusion will continue to be covered.

If you have a terminal illness, the *Plan* will notify you of *Tufts HP's* decision within five (5) days of receiving your appeal. If *Tufts HP's* decision is to deny coverage, you may request a conference.

The *Plan* will schedule the conference within 10 days (or within 5 business days if your physician determines, after talking with a *Tufts HP* medical director, that based on standard medical practice the effectiveness of the proposed treatment or alternative covered treatment would be materially reduced if not provided at the earliest possible date). You may bring another person with you to the conference. At the conference, you and/or your authorized representative, if any, and a representative of *Tufts HP* who has authority to determine the disposition of the grievance shall review the information provided.

If the appeal is denied, the decision will include the specific medical and scientific reasons for denying the coverage, and a description of any alternative treatment, services or supplies that would be covered.

If You are Not Satisfied with the Appeals Decision

"Reconsideration"

In circumstances where relevant medical information (1) was received too late to review within the thirty (30) calendar day time limit; or (2) was not received but is expected to become available within a reasonable time period following the written resolution, you may choose to request a reconsideration. *Tufts HP* may allow the opportunity for reconsideration of a final adverse determination. If you request a reconsideration you must agree in writing to a new time period for review. The time period will be no greater than thirty (30) calendar days from the agreement to reconsider the appeal.

External Review by The Office of Patient Protection

The Office of Patient Protection, which is not connected in any way with *Tufts HP*, administers an independent external review process for final coverage determinations based on medical necessity (final adverse determination). Appeals for coverage of services specifically excluded in your EOC are not eligible for external review.

To request an external review by the Office of Patient Protection you must file your request in writing with the Office of Patient Protection within forty-five (45) days of your receipt of written notice of the denial of your appeal by *Tufts HP*. The letter from the *Plan* notifying you of the denial will contain the forms and other information that you will need to file an appeal with the Office of Patient Protection.

You or your authorized representative may request to have your review processed as an expedited external review. Any request for an expedited external review must contain a certification, in writing, from a physician, that delay in the providing or continuation of health care services, that are the subject of a final adverse determination, would pose a serious and immediate threat to your health. Upon a finding that a serious and immediate threat to your health exists, the Office of Patient Protection will qualify such request as eligible for an expedited external review.

Your cost for an external review by the Office of Patient Protection is $25.00. This payment should be sent to the Office of Patient Protection, along with your written request for a review. The Office of Patient Protection may waive this fee if it determines that the payment of the fee would result in an extreme financial hardship to you. *Tufts Health Plan* will pay the remainder of the cost for an external review. Upon completion of the external review, the Office of Patient Protection shall bill *Tufts HP* the amount established pursuant to contract between the Department and the assigned external review agency minus the $25 fee which is your responsibility.

You, or your authorized representative, will have access to any medical information and records relating to your appeal, in the possession of *Tufts HP* or under its control.

If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending. The review panel may order the continuation of coverage where it determines that substantial harm to your health may result absent such continuation or for such other good cause, as the review panel shall determine. Any such continuation of coverage will be at *Tufts HP's* expense regardless of the final external review determination.

External Review by The Office of Patient Protection, continued

The decision of the review panel will be binding on *Tufts HP.* If the external review agency overturns a Tufts HP decision in whole or in part, *Tufts HP* will send you a written notice within five (5) business days of receipt of the written decision from the review agency. This notice will:

- include an acknowledgement of the decision of the review agency;
- advise you of any additional procedures for obtaining the requested coverage or services;
- advise you of the date by which the payment will be made or the authorization for services will be issued by *Tufts HP*; and
- include the name and phone number of the person at *Tufts HP* who will assist you with final resolution of the grievance.

Please note, if you are not satisfied with *Tufts HP's* member satisfaction process, you have the right at any time to contact the Commonwealth of Massachusetts at either the Division of Insurance Bureau of Managed Care or the Department of Public Health's Office of Patient Protection at:

Department of Public Health, Office of Patient Protection

250 Washington Street, 2nd Floor, Boston, MA 02108

Phone: 1-800-436-7757 / Fax: 1-617-624-5046/

Internet: www.state.ma.us/dph/opp

Bills from *Providers*

Bills from *Providers*

Medical Expenses

Occasionally, you may receive a bill from a *Provider* for *Covered Services*. Before paying the bill, contact the Member Services Department.

If you do pay the bill, you must send the following information to the Member Reimbursement Medical Claims Department:

- a completed, signed Member Reimbursement Medical Claim Form, which can be obtained from the *Tufts HP* Web site or by contacting Member Services Department; and
- the documents listed on the Member Reimbursement Medical Claim Form that are required for proof of service and payment.

The address for the Member Reimbursement Medical Claims Department is listed on the Member Reimbursement Medical Claim Form.

Send bill(s) to the *Plan* within six months after the date of service. If you do not, the bill cannot be considered for payment.

If you receive *Covered Services* from a non-*Plan Provider*, the *Plan* will pay you up to the *Reasonable Charge* for the services.

The *Plan* reserves the right to be reimbursed by the *Member* for payments made due to *Tufts Health Plan's* error.

Pharmacy Expenses

If you obtain a prescription at a non-designated pharmacy, you will need to pay for the prescription up front and submit a claim for reimbursement. Pharmacy claim forms can be obtained by contacting a Member Services Coordinator or through the *Plan's* Web site at **www.tuftshealthplan.com**.

Limitation on Actions

Limitation on Actions

You cannot file a lawsuit against *Tufts Health Plan* for failing to pay or arrange for *Covered Services* unless you have completed the *Plan's* Member Satisfaction Process and file the lawsuit within two years from the time the cause of action arose.

Chapter 6

Other Plan Provisions

Subrogation

The *Plan's* right of subrogation

You may have a legal right to recover some or all of the costs of your health care from someone else; for example:

- your own or someone else's auto or homeowner's insurer;

or

- the person who caused your illness or injury.

In that case, if *Tufts Health Plan* pays or will pay for the costs of health care services (including medications) given to treat your illness or injury, the *Plan* has the right to recover those costs in your name, with or without your consent, directly from that person or company. This is called the *Plan's* right of subrogation. The *Plan's* right has priority, except as otherwise provided by law. *Tufts Health Plan* can recover against the total amount of any recovery, regardless of whether

- all or part of the recovery is for medical expenses, or
- the recovery is less than the amount needed to reimburse you fully for the illness or injury.

Workers' compensation

Employers provide workers' compensation insurance for their employees to protect them in case of work-related illness or injury.

If you have a work-related illness or injury, you and your employer must ensure that all medical claims related to the illness or injury are billed to your employer's workers' compensation insurer. The *Plan* will not provide coverage for any injury or illness for which it determines that benefits are available under any workers' compensation coverage or equivalent employer liability, or indemnification law.

If the *Plan* pays for the costs of health care services for any work-related illness or injury, *Tufts HP* has the right to recover those costs from you, the person, or company legally obligated to pay for such services, or from the *Provider*. If your *Provider* bills services to the *Plan* for any work-related illness or injury, please contact the Liability and Recovery Department at 1-888-880-8699, x.1098.

Subrogation, Continued

The *Plan's* right of reimbursement

In addition to the rights described above, if you recover money by suit, settlement, or otherwise, you are required to reimburse Tufts HP for the cost of health care services, supplies, medications, and expenses for which Tufts HP paid or will pay. Tufts HP has the right to be reimbursed up to the amount of any payment received by you, regardless of whether (a) all or part of the payment to you was designated, allocated, or characterized as payment for medical expenses; or (b) the payment is for an amount less than that necessary to reimburse you fully for the illness or injury.

Assignment of benefits

You hereby assign to the *Plan* any benefits you may be entitled to receive from a person or company that caused, or is legally responsible to reimburse you for your illness or injury. Your assignment is up to the cost of health care services and supplies, and expenses that the *Plan* paid or will pay for your illness or injury.

***Member* cooperation**

You agree:

- to notify the *Plan* of any events which may affect the *Plan's* rights of recovery under this section, such as:
  - injury resulting from an automobile accident, or
  - job-related injuries that may be covered by workers' compensation;
- to cooperate with the *Plan* by
  - giving the *Plan* information and help, and
  - signing documents to help the *Plan* get reimbursed;
- that the *Plan* may
  - investigate,
  - request and release information which is necessary to carry out the purpose of this section to the extent allowed by law, and
  - do the things the *Plan* decides are appropriate to protect the *Plan's* rights of recovery.

Subrogation Agent

The *Plan* may contract with a third party to administer subrogation recoveries. In such case, that subcontractor will act as the *Plan's* agent.

Coordination of Benefits

Benefits under other plans

You may have benefits under other plans for hospital, medical, dental or other health care expenses.

The *Plan* has a coordination of benefits program (COB) that prevents duplication of payment for the same health care services. We will coordinate benefits payable for *Covered Services* with benefits payable by other plans, consistent with state law.

Note: We coordinate benefits with Medicare according to federal law, rather than state law.

Primary and secondary plans

The *Plan* will coordinate benefits by determining

- which plan has to pay first when you make a claim, and
- which plan has to pay second.

The *Plan* will make these determinations according to applicable state law.

Right to receive and release necessary information

When you enroll, you must include information on your membership application about other health coverage you have.

After you enroll, you must notify the *Plan* of new coverage or termination of other coverage. The *Plan* may ask for and give out information needed to coordinate benefits.

You agree to provide information about other coverage and cooperate with the *Plan's* COB program.

Right to recover overpayment

The *Plan* may recover, from you or any other person or entity, any payments made that are greater than payments it should have made under the COB program. The *Plan* will recover only overpayments actually made.

For more information

For more information about COB, contact the *Plan's* Liability Recovery (COB) Department at 1-888-880-8699, x.1098.

Use and Disclosure of Medical Information

The *Plan* mails a separate "Notice of Privacy Practices" to all *Subscribers* to explain how the *Plan* uses and discloses your medical information. If you have questions or would like another copy of the "Notice of Privacy Practices", please call Member Services at 1-800-870-9488. Information is also available on the *Plan's* Web site at **www.tuftshealthplan.com**.

Relationships between the *Plan* and *Providers*

The Plan* and *Providers

The *Plan* arranges health care services. The *Plan* does not provide health care services. The *Plan* has agreements with *Providers* practicing in their private offices throughout the *Service Area*. These *Providers* are independent. They are not *Plan* employees, agents or representatives. *Providers* are not authorized to:

- change this *Evidence of Coverage*; or
- assume or create any obligation for the *Plan*.

The *Plan* is not liable for acts, omissions, representations or other conduct of any *Provider*.

Circumstances Beyond the *Plan's* Reasonable Control

Circumstances beyond the *Plan's* reasonable control

The *Plan* shall not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond the reasonable control of the *Plan*. Such circumstances include, but are not limited to: major disaster; epidemic; strike; war; riot; and civil insurrection. In such circumstances, the *Plan* will make a good faith effort to arrange for the provision of services. In doing so, the *Plan* will take into account the impact of the event and the availability of *Plan Providers*.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The *GIC* has more generous guidelines for benefit coverage that apply to persons subject to USERRA as set forth below:

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your *Dependents* while in the military.
- If you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed.
- Service members who elect to continue their *GIC* health coverage are required to pay the employee share for such coverage.
- USERRA coverage runs concurrently with COBRA and other state continuation coverage.
- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at **www.dol.gov/vets**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information, please contact the *Group Insurance Commission.*

Group Contract

Acceptance of the terms of the *Group Contract*

By signing and returning the membership application form, you apply for *Group* coverage and agree to all the terms and conditions of the *Group Contract*, including this *Evidence of Coverage*.

Payments for coverage

The *Plan* will bill the *Group Insurance Commission* and the *GIC* will pay *Premiums* to the *Plan* for you. The *Plan* is not responsible if the *Group Insurance Commission* fails to pay the *Premium*.

Note: If the *Group Insurance Commission* fails to pay the *Premium* on time, the *Plan* may cancel your coverage in accordance with the *Group Contract* and applicable state law.

The *GIC* may change the *Premium*. If the *Premium* is changed, the change will apply to all *Members* enrolled in this *Group Insurance Commission* option.

Changes to this *Evidence of Coverage*

The Plan may change this *Evidence of Coverage* subject to *GIC* approval. Changes do not require your consent. Notice of changes in *Covered Services* will be sent to the *Group Insurance Commission* at least 60 days before the effective date of the modifications and will

- include information regarding any changes in clinical review criteria; and
- detail the effect of such changes on a *Member's* personal liability for the cost of such changes.

An amendment to this *Evidence of Coverage* describing the changes will be sent to you and will include the effective date of the change. Changes will apply to all benefits for services received on or after the *Effective Date* with one exception.

Exception: A change will not apply to you if you are an *Inpatient* on the effective date of the change until the earlier of

- your discharge date, or
- the date *Annual Coverage Limitations* are used up.

Note: If changes are made, they will apply to all *Members*, not just to you.

Notice

Notice to *Members*: We may send notice to you of information affecting your *Tufts Health Plan* coverage. When we send a notice to you, it will be sent to your last address on file with us. The *Plan* usually will not send notices to you. The *Plan* will send each notice to the *Group Insurance Commission*.

Notice to us: *Members* should address all correspondence to:

Tufts Health Plan
705 Mt. Auburn Street
Watertown, MA 02472-1508

Enforcement of terms

Tufts HP may choose to waive certain terms of the *Group Contract*, if applicable, including the *Evidence of Coverage*. This does not mean that *Tufts HP* gives up its rights to enforce those terms in the future.

When this *Evidence of Coverage* is Issued and Effective

This *Evidence of Coverage* is issued and effective July 1, 2008 and supersedes all previous *Evidences of Coverage*.

Appendix A

Glossary of Terms

Terms and Definitions

Term/ definition table The table below defines the terms used in this *Evidence of Coverage*.

Term	Definition
Annual Coverage Limitations	Annual dollar or time limitations on *Covered Services*.
Authorized Reviewer	*Authorized Reviewers* review and approve certain services and supplies to *Members*. They are: • the *Plan's* Chief Medical Officer (or equivalent); or • someone he or she names.
Benefit Period	The way that Medicare measures your use of hospital and *Skilled* nursing facility services. A *Benefit Period* begins the day you go to a hospital or *Skilled* nursing facility. The *Benefit Period* ends when you have not received hospital or *Skilled* nursing care for 60 days in a row. If you go into the hospital after one *Benefit Period* has ended, a new *Benefit Period* begins. You must pay the *Inpatient* hospital deductible for each *Benefit Period*. There is no limit to the number of *Benefit Period*s you can have.
Biologically-based Mental Disorders	The following *Mental Disorders*: • schizophrenia; • schizoaffective disorder; • major depressive disorder; • bipolar disorder; • paranoia and other psychotic disorders; • obsessive-compulsive disorder; • panic disorder; • delirium and dementia; • affective disorders; and • any other mental disorders added by the Commissioners of the Department of Mental Health and the Division of Insurance. Note: See pages 3-21, 3-22 and 3-24 for information regarding coverage for *Biologically-based Mental Disorders*.

Terms and Definitions, Continued

Term	Definition
Coinsurance	The percentage of costs you must pay for certain *Covered Services*. For services provided by a Non-*Plan Provider*, your share is a percentage of the *Reasonable Charge* for those services. For services provided by a *Plan Provider*, your share is a percentage of: • the applicable *Plan* fee schedule amount for those services; and • the *Plan Provider's* actual charges for those services, whichever is less.
Copayment	Fees you pay for *Covered Services*. *Copayments* are paid to the *Provider* when you receive care unless the *Provider* arranges otherwise.
Covered Services	The services and supplies for which the *Plan* will pay. They must be • described in Chapter 3; • *Medically Necessary*; and • given or authorized by your *PCP* and in some cases approved by an *Authorized Reviewer*.
Covering Physician	The physician named by your *PCP* to give or authorize services in your *PCP's* absence.

Term	Definition
Custodial Care	• Care given primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety; • care given primarily for maintaining the *Member's* or anyone else's safety, when no other aspects of treatment require an acute hospital level of care; • services that could be given by people without professional skills or training; or • routine maintenance of colostomies, ileostomies, and urinary catheters; or • adult and pediatric day care. In cases of mental health care, *Inpatient* care given primarily • for maintaining the *Member's* or anyone else's safety, or • for the maintenance and monitoring of an established treatment program, when no other aspects of treatment require an acute hospital level of care. Note: *Custodial Care* is not covered by the *Plan*.
Day Surgery	Any surgical procedure(s) in an operating room under anesthesia for which the *Member* is admitted to a facility licensed by the state to perform surgery, and with an expected discharge the same day, or in some instances, within twenty-four hours. For hospital census purposes, the *Member* is an *Outpatient* not an *Inpatient*. Also referred to as "Ambulatory Surgery" or "Surgical Day Care."
Deductible	The amount you must pay for health care, before Medicare begins to pay for Medicare *Covered Services*. There is a *Deductible* for each *Benefit Period* for Part A, and each year for Part B. These amounts can change every year.

Term	Definition
Directory of Health Care Providers	A separate booklet which lists • *Plan PCPs* and their affiliated *Plan Hospital*; and • certain other *Plan Providers*. Note: This booklet is updated from time to time to show changes in *Providers* affiliated with the *Plan*. For information about the *Providers* listed in the *Directory of Health Care Providers*, you can call Member Services at 1-800-870-9488 or check the *Plan's* Web site at **www.tuftshealthplan.com**.
Durable Medical Equipment	Devices or instruments of a durable nature that • are reasonable and necessary to sustain a minimum threshold of independent daily living; • are made primarily to serve a medical purpose; • are not useful in the absence of illness or injury; • can withstand repeated use; and • can be used in the home.
Effective Date	The date, according to the *Plan's* records, when you become a *Member* and are first eligible for *Covered Services*.
Emergency	An illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity including severe pain that the absence of prompt medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in: • serious jeopardy to the physical and / or mental health of a *Member* or another person (or with respect to a pregnant *Member*, the *Member's* or her unborn child's physical and / or mental health); • serious impairment to bodily functions; or • serious dysfunction of any bodily organ or part; or • with respect to a pregnant woman who is having contractions, inadequate time to effect a safe transfer to another hospital before delivery, or a threat to the safety of the *Member* or her unborn child in the event of transfer to another hospital before delivery. Some examples of illnesses or medical conditions requiring *Emergency* care are severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, or any medical condition that is quickly getting much worse.
Evidence of Coverage	This document and any future amendments.

Terms and Definitions, Continued

Term	Definition
Experimental or Investigative	A service, supply, treatment, procedure, device, or medication (collectively "treatment") is considered *Experimental or Investigative* if any of the following is true: • the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished; or • the treatment, or the "informed consent" form used with the treatment, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval; or • reliable evidence shows that the treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis; or • reliable evidence shows that more studies or clinical trials are necessary to determine its safety, efficacy, and positive effects on health outcomes. **Important Note:** Reliable evidence showing more studies or clinical trials are necessary is based on the following two sources: • Hayes Report ratings: Hayes is an independent health technology assessment organization. Hayes Technology Reports are independent, evidence-based analyses of the safety, efficacy, and cost-effectiveness of emerging health technologies. Hayes reports are developed by a team of medical research analysts, information specialists, reviewers and editors. A treatment with a Hayes C or Hayes D rating is considered experimental or investigative. • Peer reviewed published literature that is predominately non-randomized, historically controlled trials, case control or cohort studies with a high risk of confounding or bias, case reports or series, and/or expert opinion all indicate that more studies or clinical trials are necessary to determine the treatment's safety, efficacy, and positive effects on health outcomes.

Terms and Definitions, Continued

Term	Definition
Group Contract	The agreement between *Tufts Health Plan* and the *Group Insurance Commission* under which • *Tufts Health Plan* agrees to provide *Group* Coverage to you; and • the *Group Insurance Commission* agrees to pay a *Premium* to the *Plan* on your behalf. The *Group Contract* includes this *Evidence of Coverage* and any amendments.
Group Insurance Commission	The Massachusetts state agency responsible for purchasing this health care program for employees and retirees of the Commonwealth of Massachusetts and *Participating Municipalities*. Also referred to as "the Commission" or "GIC."
Individual Coverage	Coverage for a *Subscriber* only.
Inpatient	A patient who is • admitted to a hospital or other facility licensed to provide continuous care; and • classified as an *Inpatient* for all or a part of the day on the facility's *Inpatient* census.
Medically Necessary	A service or supply that is consistent with generally accepted principles of professional medical practice as determined by whether that service or supply: • Is the most appropriate available supply or level of services for the *Member* in question considering potential benefits and harms to that individual; • Is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or • for services and interventions not in widespread use, is based on scientific evidence. In determining coverage for *Medically Necessary* Services, the *Plan* uses *Medical Necessity* coverage guidelines which are: • developed with input from practicing physicians in the *Service Area*; • developed in accordance with the standards adopted by national accreditation organizations; • updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and • evidence-based, if practicable. Note: For those services covered by Medicare, Medicare determines what is *Medically Necessary*.

Terms and Definitions, Continued

Term	Definition
Member	A person enrolled in *Tufts Health Plan* under the *Group Contract*, also referred to as "you."
Mental Disorders	Psychiatric illnesses or diseases listed as *Mental Disorders* in the latest edition, at the time treatment is given, of the American Psychiatric Association's Diagnostic and Statistical Manual: Mental Disorders.
Open Enrollment Period	The period each year when the *Group Insurance Commission* allows eligible persons to apply for *Group* coverage under this plan and other health plans offered by the GIC.
Outpatient	A patient who receives care other than on an *Inpatient* basis. This includes services provided in: • a physician's office; • a *Day Surgery* or ambulatory care unit; and • an *Emergency* room or outpatient clinic.
Participating Municipality	A city, town or district in the Commonwealth of Massachusetts that participates in the insurance plan offered by the *Group Insurance Commission*.
The Plan	See Tufts Health Plan.
Plan Hospital	See Tufts Health Plan Hospital.
Plan Provider	See Tufts Health Plan Provider.
Premium	The total monthly cost of *Individual Coverage* which the *Group Insurance Commission* pays to *Tufts Heath Plan*.
Primary Care Physician (PCP)	The *Tufts Health Plan* physician you have chosen from the *Directory of Health Care Providers* and who has an agreement with the *Plan* to provide primary care and to coordinate, arrange, and authorize the provision of *Covered Services*.

Term	Definition
Provider	A health care professional or facility licensed in accordance with applicable state law, including, but not limited to, hospitals, physicians, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, psychiatrists, psychologists, licensed mental health counselors, licensed independent clinical social workers, licensed psychiatric nurses who are certified as clinical specialists in psychiatric and mental health nursing, licensed speech-language pathologists, and licensed audiologists. The *Plan* will only cover services of a *Provider*, if those services are: • listed as *Covered Services*; and • within the scope of the *Provider's* license. Notes: • With respect to *Outpatient* services for the treatment of alcoholism, *Provider* means an accredited or licensed hospital or any public or private facility or portion of that facility providing services especially for the rehabilitation of intoxicated persons or alcoholics and which is licensed by the Massachusetts Department of Public Health or under other applicable state law. • With respect to *Inpatient* Services for the treatment of alcoholism, *Provider* means: an accredited or licensed hospital or any public or private facility or portion of that facility providing services especially for the detoxification or rehabilitation of intoxicated persons or alcoholics and which is licensed by the Massachusetts Department of Public Health; or a residential alcohol treatment program, as defined under Massachusetts law or other applicable state law.
Provider Unit	A *Provider Unit* is comprised of doctors and other health care *Providers* who practice together in the same community and who often admit patients to the same hospital in order to provide their patients with a full range of care. Also referred to as "*Provider* Group".
Rape-related Mental or Emotional Disorder	A mental or emotional disorder related to a *Member* who is a victim of rape or assault with intent to commit rape. *Rape-related Mental or Emotional Disorders* are covered when the costs for treatment exceed the maximum amount awarded under applicable Massachusetts law. Note: See pages 3-21, 3-22 and 3-24 for information regarding coverage for *Rape-related Mental or Emotional Disorders*.

Term	Definition
Reasonable Charge	The lesser of the: • amount charged; or • amount that the *Plan* determines, based upon nationally accepted means of claims payment and the fees most often charged by similar *Providers* for the same service in the geographic area in which it is given, to be the reasonable amount for the service. Nationally accepted means of claims payment includes, but is not limited to: CMS medical coding policies, AMA CPT coding guidelines, nationally recognized academy and society coding and clinical guidelines. Also referred to as "*Usual and Customary* Charge".
Reserve Days	Sixty days that Medicare will pay for when you are put in a hospital for more than 90 days of Medicare *Covered Services*. These 60 *Reserve Days* can be used only once during your lifetime. For each lifetime *Reserve Day*, Medicare pays all covered costs except for a daily *Coinsurance* amount.
Service Area	The Service Area (sometimes referred to as the "Enrollment Service Area"), which is the geographical area within which the *Plan* has developed a network of *Providers* to afford *Members* with adequate access to *Covered Services*. The Enrollment Service Area consists of the Primary Service Area and the Extended Service Area. The Primary Service Area is comprised of: • all of Massachusetts, except Nantucket and Martha's Vineyard; and • the cities and towns in New Hampshire and Rhode Island in which *Plan PCPs* are located. The Extended Service Area includes certain towns in Connecticut, New Hampshire, Rhode Island and Vermont which surround the Primary Service Area and are within a reasonable distance to the location of *Primary Care Physicians*. Notes: • There are generally no *Plan PCPs* located within the Extended Service Area. • For a list of cities and towns in the Service Area, you can call Member Services at 1-800-870-9488 or check the *Plan's* Web site at **www.tuftshealthplan.com**.

Terms and Definitions, Continued

Term	Definition
Skilled	A type of care which is *Medically Necessary* and must be provided by, or under the direct supervision of, licensed medical personnel. Skilled care is provided to achieve a medically desired and realistically achievable outcome.
Spouse	The *Subscriber's* legal spouse, according to the law of the state in which you reside.
Subscriber	The person who: • is a Medicare-eligible retired employee or a Medicare-eligible surviving spouse of a retired employee of the Commonwealth of Massachusetts or a *Participating Municipality*; • enrolls in this plan and signs the membership application form on behalf of himself or herself; and • in whose name the *Premium* is paid.
Tufts Health Plan or the Plan	Tufts Associated Health Maintenance Organization, Inc., a Massachusetts corporation d/b/a Tufts Health Plan. Tufts Health Plan is licensed by Massachusetts as a health maintenance organization (HMO). Also referred to as "the *Plan*".
Tufts Health Plan Hospital or Plan Hospital	A hospital which has an agreement with *Tufts Health Plan* to provide certain *Covered Services* to *Members*. *Plan Hospitals* are independent. They are not owned by *Tufts Health Plan*. *Plan Hospitals* are not *Tufts Health Plan's* agents or representatives, and their staff are not *Tufts Health Plan's* employees.
Tufts Health Plan Provider or Plan Provider	A *Provider* with which *Tufts Health Plan* has an agreement to provide *Covered Services* to *Members*. *Providers* are not *Tufts Health Plan's* employees, agents or representatives.
Urgent Care	Care provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. Examples of illnesses or injuries in which urgent care might be needed are a broken or dislocated toe, a cut that needs stitches but is not actively bleeding, sudden extreme anxiety, or symptoms of a urinary tract infection. Note: Care that is rendered after the *Urgent* condition has been treated and stabilized and the *Member* is safe for transport is not considered *Urgent Care*.
Usual and Customary Charge	See "*Reasonable Charge*".

Appendix B – Non-Covered Drugs With Suggested Alternatives

This list of non-covered drugs is effective January 1, 2008 and may change during the year. Drugs may be added to this list for safety reasons, when a new drug comes to market, or if a prescription drug becomes available over-the-counter [or if a generic version of a drug becomes available].

IMPORTANT NOTE: Please see our Web site at **www.tuftshealthplan.com** for the most current list or call a Member Services Coordinator.

Brand Name	Suggested Alternatives
Abilify Discmelt	Abilify tablets
Abilify Solution	Abilify tablets
Accupril	quinapril
Accuretic	quinapril/hydrochlorothiazide
AcipHex	Prilosec OTC (OTC, not covered), omeprazole, Nexium or Prevacid
Alcet	oxycodone/acetaminophen
Alodox kit	doxycycline
Altoprev	lovastatin tablets
Ambien	zolpidem tartrate
Ambien CR	zolpidem tartrate
Amrix	cyclobenzaprine
Appbutamone	bupropion
Appbutamone-D	bupropion
Appformin	metformin
Appformin-D	metformin
Aquoral	saliva substitute (OTC, not covered), Salagen
Atacand	Benicar, Cozaar, or Diovan
Atacand HCT	Benicar HCT, Diovan HCT or Hyzaar
Auralgan	A/B Otic, Benzotic, Aurodex
Avalide	Benicar HCT, Diovan HCT, or Hyzaar
Avapro	Benicar, Cozaar, or Diovan
Axid capsules	cimetidine, famotidine, nizatidine, or ranitidine
Beconase AQ	fluticasone nasal spray, flunisolide nasal spray
Benziq	*benzoyl peroxide*
Benziq LS	benzoyl peroxide
Binora	benzoyl peroxide
Bionect	Kerodex (OTC, not covered)
Brevoxyl-4 kit	benzoyl peroxide creamy wash
Brevoxyl-8 kit	benzoyl peroxide creamy wash

Appendix B – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Caphosol	saliva substitute (OTC, not covered)
Capoten	captopril
Capozide	captopril/hydrochlorothiazide
Centany	mupirocin ointment, Bactroban cream
Clarinex	loratidine (OTC, not covered), fexofenadine
Clarinex-D 12-Hour	fexofenadine plus pseudoephedrine (pseudoephedrine is OTC, not covered)
Clarinex-D 24-Hour	loratidine plus pseudoephedrine, fexofenadine plus pseudoephedrine (pseudoephedrine is OTC, not covered)
Cleeravue-M	minocycline
ClindaReach	clindamycin phosphate 1%
Clobex spray	clobetasol
Combunox	oxycodone/ibuprofen
Coreg CR	carvedilol
Desonate	desonide cream/lotion
Durabac Forte	Mobigesic (OTC, not covered), acetaminophen (OTC, not covered)
Dynacin	minocycline capsules
EC Naprosyn	enteric-coated naproxen
Efudex (5% occlusion pack/kit)	Fluorouacil cream
Eletone	Eucerin (OTC, not covered), Moisturin (OTC, not covered)
Emsam	selegiline tablets
Extina	ketoconazole cream or shampoo
Exubera	Humalog vial or Novolog vial
Factive	ciprofloxacin, ofloxacin, or Levaquin
Fentora	fentanyl citrate lollipop, Actiq
Fexmid	cyclobenzaprine
Flagyl, Flagyl ER	metronidazole tablets
Fortamel	metformin extended-release
Freshkote	Puralube tears (OTC, not covered)
Gabazolamine	alprazolam
Gabitidine	ranitidine
Gaboxetine	fluoxetine
Genotropin	Norditropin, Norditropin Nordiflex
Glumetza	metformin ER
Glycolax	Miralax (OTC, not covered)
Humatrope	Norditropin, Norditropin Nordiflex
Hydro 40	urea lotion, urea cream
Hylira	Eucerin cream (OTC, not covered)
Hypertensolol	metoprolol
Inova	benzoyl peroxide wash, Stridex (OTC, not covered)

Appendix B – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Inova 4/1, 8/2	benzoyl peroxide wash, Stridex (OTC, not covered)
Invega	Risperdal, Seroquel, Zyprexa
Iplex	Increlex
itraconazole capsules	terbinafine tablets
Kerafoam	urea lotion, urea cream
Keralac Nailstik	urea nail gel, Keralac nail gel
Keralyt	Keralyt (OTC, not covered)
Kerol Redi-Cloths	urea cream, urea lotion
Kerol Topical Suspension	urea cream, urea lotion
Ketotifen Fumarate Ophthalmic Drops	Zaditor (OTC, not covered)
Klonopin	clonazepam
Klonopin wafers	clonazepam
Lagesic	Aceta-Gesic (OTC, not covered), Hyflex-DS
Lavoclen-4 kit	Lavoclen-4 topical liquid
Lavoclen-8 kit	Lavoclen-8 topical liquid
Lialda	Asacol, Pentasa
Lidosite	Lidocaine-prilocaine cream
Lipofen	fenobirate, Tricor
Liquicef	hydrocodone bitartrate/APAP, Hycet oral solution
Lopressor	metoprolol
Lotensin	benazepril
Lotensin	Benazepril/hydrochlorothiazide
Lovaza	omega-3 fish oil (OTC, not covered)
Lupron 1mg/0.2mL vial and kit	leuprolide 1mg/0.2mL vial and kit
Lynox	oxycodone with acetaminophen tablets
Lytensopril	lisinopril tablets
Magnacet	oxycodone with acetaminophen tablets
Mavik	trandolapril
Megace ES	megestrol acetate oral suspension
Metrogel Combo Pak	metronidazole topical gel 0.75%, Metrogel 1%
metronidazole 375 mg	metronidazole tablets
Mevacor	lovastatin
Micardis	Benicar, Cozaar, or Diovan
Micardis HCT	Benicar HCT, Diovan HCT or Hyzaar
Minocin	minocycline capsules
Miralax	Miralax (OTC, not covered)
Mobic oral suspension	meloxicam
Monodox	doxycyline monohydrate
Monopril	fosinopril
Monopril-HCT	fosinopril/hydrochlorothiazide
Mucotrol	Gelclair
Myrac	minocycline tablets

Appendix B – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Namenda oral solution	Namenda tablets
Naprelan	naproxen sodium extended-release
Neobenz Micro	benzoyl peroxide
Neobenz Micro SD	benzoyl peroxide
Niravam	alprazolam
Noxafil	fluconazole
Numoisyn	saliva substitute (OTC, not covered), Salivart
Nutropin	Norditropin, Norditropin Nordiflex
Nutropin AQ	Norditropin, Norditropin Nordiflex
Olux-E	Olux foam, clobetasole propionate emollient cream
Omnitrope	Norditropin, Norditropin Nordiflex
Opana	hydromorphone tablets, oxycodone tablets
Opana ER	oxycodone ER
Oracea	doxycycline
Orapred ODT	prednisolone sodium phosphate solution
Otosporin	Star-Otic (OTC, not covered)
Pataday	Zaditor (OTC, not covered), Patanol
Pepcid (except suspension)	cimetidine, famotidine, or ranitidine tablets
Peranex HC	lidocaine-hydrocortisone-aloe kit
Perloxx	oxycodone/acetaminophen
polyethylene glycol 3350 oral powder	Miralax (OTC, not covered)
Pravachol	Pravastatin
Prazolamine	carisoprodol tablets
Prevacid Naprapac	naproxen plus Prilosec OTC (OTC, not covered), omeprazole, Nexium or Prevacid
Prilosec	Prilosec OTC (OTC, not covered), omeprazole, Nexium, or Prevacid PLEASE NOTE: Prilosec is covered for members 12 years of age and younger
Prinivil	lisinopril
Prinzide	lisinopril/hydrochlorothiazide
Proquin XR	ciprofloxacin
Prosed/DS	Uretron D/S, Urin D.S.
Pulmicort Flexhaler	Asmanex, Flovent HFA
Pulmophylline	theophylline
Pylera	PrevPac, Helidac
Rectagel HC	Lidocaine-HC cream
Relamine	glucosamine/chondroitin (OTC, not covered)
Reprexain	hydrocodone/ibuprofen

Appendix B – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Rimantalist	rimantadine
Rinnovi Nail System	urea cream, urea nail gel
Rosac wash	Clenia cleanser, Avar cleanser
Rosula cleanser	Prascion, Sulfatol
Rosula wash	Clenia cleanser, Avar cleanser
Saizen	Norditropin, Norditropin Nordiflex
Senophylline	theophylline tablets
Sentradine	ranitidine
Sentroxatine	fluoxetine
Servira	Donnatal Extentabs
Solodyn	minocycline tablets
Soma 250 mg	carisoprodol tablets
Sporanox capsules	terbinafine tablets (prior authorization required)
Staflex	Aceta-Gesic (OTC, not covered), Hyflex-DS
Strazepam	temazepam capsules
Taclonex	betamethasone dipropionate/calcipotriene ointment
Tandem F	Tandem (OTC, not covered) plus folic acid
Tekturna	lisinopril, enalapril, Benicar, Cozaar, or Diovan
Tersi Foam	selenium sulfide shampoo
Teveten	Benicar, Cozaar, or Diovan
Teveten HCT	Benicar HCT, Diovan HCT or Hyzaar
Tev-Tropin	Norditropin, Norditropin Nordiflex
Therabenzaprine	cyclobenzaprine
Theracodophen/Theracodophen-Low	hydrocodone/acetaminophen tablets
Therafeldamine	piroxicam
Therapentin	gabapentin
Theraprofen	Ibuprofen
Theraproxen	naproxen sodium tablets
Theratramadol	tramadol
Trazamine	trazadone tablets
Tretin-X	tretinoin cream/gel
Triple Dye	Triple Dye Liquid (OTC, not covered)
Ultralytic 2	ammonium lactate
Ultram ER	tramadol
Umecta PD Topical Emulsion, Adhesive 40%	urea lotion, Umecta Topical Suspension
Umecta PD Topical Suspension, Adhesive 40%	urea lotion, Umecta Topical Suspension
Unirectic	moexipril/hydrochlorothiazide
Univasc	moexipril
urea nail stick 50%	urea nail gel 50%

Appendix B – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Valium	diazepam
Vaseretic	enalapril/hydrochlorothiazide
Vasotec	enalapril
Veramyst	fluticasone propionate nasal spray
Verdeso	desonide cream/lotion
Vicoprofen	hydrocodone/ibuprofen
VSL#3 DS	VSL#3 (OTC, not covered)
Vusion	miconazole nitrate & zinc oxide (OTC, not covered)
Vyvanse	Concerta, Adderall XR
Xanax	alprazolam
Xanax XR	alprazolam extended-release
Xclair	Xenaderm ointment
Xolegel	ketoconazole cream
Xolegel Duo	ketoconazole cream plus Dandruff Shampoo (Dandruff Shampoo is OTC, not covered)
Xyralid	lidocaine-HC cream
Xyralid LP	lidocaine-HC lotion
Xyralid RC	lidocaine-HC rectal
Zaditor	Zaditor OTC
Zegerid	Prilosec OTC (OTC, not covered), omeprazole, Nexium or Prevacid
Zelapar	selegiline tablets
Zestoretic	lisinopril/hydrochlorothiazide
Zestril	lisinopril
Ziana	tretinoin gel and clindamycin gel
Zinotic	Pramotic, Zolene HC
Zocor	simvastatin
Zoderm Redi-Pads	benzoyl peroxide
Zyflo CR	Singulair, Accolate
Zytopic	triamcinolone acetonide cream or ointment

GROUP INSURANCE COMMISSION NOTICES

FOR SUBSCRIBERS ENROLLED IN TUFTS MEDICARE COMPLEMENT (TMC) PLAN

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

You are receiving this notice because you are covered under the *Group Insurance Commission's* (*GIC's*) health benefits program. This notice contains important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

WHAT IS COBRA COVERAGE? COBRA is a federal law under which certain former employees, retirees, *Spouses*, former *Spouses* and *Dependent Children* have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the *GIC's* plan to similarly situated employees or *Dependents*. The *GIC* administers COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the *GIC's* Public Information Unit at 617/727-2301, ext. 801 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa**.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family *members* elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts or a *Participating Municipality* covered by the *GIC's* Health benefits program, you have the right to choose COBRA coverage if

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the *Spouse* of an employee covered by the *GIC's* health benefits program, you have the right to choose COBRA coverage for yourself if you lose *GIC* health coverage for any of the following reasons (known as "qualifying events"):

- Your *Spouse* dies;
- Your *Spouse's* employment with the Commonwealth, *Participating Municipality*, or other entity ends for any reason other than gross misconduct or his/her hours or employment are reduced; or
- You and your *Spouse* divorce, legally separate, or you or your former *Spouse* remarries.

If you have *Dependent Children* who are covered by the *GIC's* health benefits program, each *Child* has the right to elect COBRA coverage if he or she loses *GIC* health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- The parents divorce or legally separate; or
- The *Dependent* ceases to be a *Dependent Child* (e.g., is over age 19 and is not a full time student, or ceases to be a full-time student).

HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce - occurs during the 18 months of COBRA coverage. **You must notify the *GIC* in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage**. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the *GIC* with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage**.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts no longer provides group health coverage to any of its employees or to an employee's *Participating Municipality*; or
- Any reason for which the *GIC* terminates a non-COBRA enrollee's coverage (such as fraud).

The *GIC* will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The *GIC* reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage**.

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under Federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a *Spouse's* plan) within 30 days after your COBRA coverage ends.

HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the *GIC* receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period**. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The *GIC* will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement**. Payments should be sent to the *GIC's* address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA? Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

YOUR COBRA COVERAGE RESPONSIBILITIES

- **You must inform the *GIC* of any address changes to preserve your COBRA rights;**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above**. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill**. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.

- **You must inform the *GIC* within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
    - The employee's job terminates or his/her hours are reduced;
    - The employee or former employee dies;
    - The employee divorces or legally separates;
    - The employee or employee's former Spouse remarries;
    - A covered Child ceases to be a Dependent;
    - The Social Security Administration determines that the employee or a covered family member is disabled; or
    - The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the *GIC* of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the *GIC* of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

Important Notice

About Your Prescription Drug Coverage and Medicare

The Centers for Medicare Services requires that this NOTICE OF CREDITABLE COVERAGE be sent to you. Please read it carefully and keep it where you can find it.

Starting January 1, 2006, new Medicare prescription drug coverage became available to everyone with Medicare. This notice:

- applies to you only if you are currently Medicare-eligible or if you should become Medicare-eligible within the coming year;
- provides information about your GIC-sponsored drug coverage and the new Medicare drug coverage to help you decide whether to enroll in one of the Medicare drug plans;
- explains your options; and
- tells you where to find more information to help you make a decision.

FOR MOST PEOPLE, THE DRUG COVERAGE YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE NEW MEDICARE DRUG PLANS', SO YOU DO NOT NEED TO PAY FOR ADDITIONAL DRUG COVERAGE.

Medicare Drug Plans

The Medicare prescription drug benefit, also known as Medicare Part D, is offered through various health plans and other organizations. All Medicare prescription drug plans provide at least the standard level of coverage set by Medicare; some plans also offer more coverage for a higher monthly premium. In order to decide whether to join a Medicare drug plan, compare which drugs the Medicare drug plans in your area cover and their costs, and consider the following information:

- **You can continue to receive prescription drug coverage through your GIC health plan rather than joining a new Medicare drug plan. Most GIC members do not need to do anything and should not enroll in a Medicare drug plan.**
- Your GIC drug coverage is part of your GIC health insurance, which pays for your health expenses as well as your prescription drugs.
- If you elect Medicare drug coverage, you will have to pay for the entire Medicare drug coverage premium.
- If you should enroll in a Medicare drug plan while you are also enrolled in Fallon Senior Plan, Harvard Pilgrim Health Care First Seniority Freedom or Tufts Health Plan Medicare Preferred

(formerly Secure Horizons), you will lose your *GIC*-sponsored health plan coverage under current Medicare rules.

- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available on-line at **www.socialsecurity.gov**, or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

Creditable Coverage Information

Your GIC prescription drug coverage is, on average, expected to pay out at least as much as the standard Medicare drug coverage pays. This means that your GIC coverage is "Creditable Coverage." You may need to show this notice to the Social Security Administration as proof that you have Creditable Coverage (to avoid paying a premium penalty), if you later enroll in a Medicare drug plan.

If you drop or lose your *GIC* coverage and do not enroll in a Medicare prescription drug plan soon after your *GIC* coverage ends, you could be required to pay a premium penalty for Medicare drug coverage when you do enroll. If your *GIC* coverage ends and you delay 63 days or longer to enroll in Medicare drug coverage, you will have to pay a premium penalty for as long as you have Medicare drug coverage. Your monthly Medicare drug premium will go up at least 1% per month for every month after May 15, 2006 (or the month of your 65th birthday, whichever is later) that you do not have creditable drug coverage. In addition, you may have to wait until the next Medicare annual enrollment period to enroll.

For more information about this notice or your prescription drug coverage options:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit **www.medicare.gov**.
- Call the *Group Insurance Commission* at 1-617-727-2310.

Notice of Group Insurance Commission Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the *GIC* must protect the privacy of your personal health information. The *GIC* retains this type of information because you receive health benefits from the *Group Insurance Commission*. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The *GIC* will abide by the terms of this notice. Should our information practices materially change, the *GIC* reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

Required and Permitted Uses and Disclosures

We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the *GIC* to make without your authorization:

Payment activities: The *GIC* may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations: The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

Other Permitted Uses and Disclosures:
The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made on your behalf (such as appeals);
- to verify agency and plan performance (such as audits);
- to communicate with you about your *GIC*-sponsored benefits (such as your annual benefits statement);
- for judicial and administrative proceedings (such as in response to a court order);
- for research studies that meet all privacy requirements;
- to tell you about new or changed benefits and services or health care choices.

Required Disclosures: The *GIC* **must** use and share your PHI when requested by you or someone who has the legal right to act for you (your Personal Representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations that Assist Us: In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI.

Except as described above, the *GIC* will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the *GIC* will not be able to get back your health information we have already used or shared based on your permission.

Your rights

You have the right to:

- Ask to see and get a copy of your PHI that the *GIC* maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the *GIC* did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The *GIC* may charge you to cover certain costs, such as copying and postage.
- Ask the *GIC* to amend your PHI if you believe that it is wrong or incomplete and the *GIC* agrees. You must ask for this in writing, along with a reason for your request. If the *GIC* denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the *GIC* shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
- Ask the *GIC* to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the *GIC* will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the *GIC* to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive a separate paper copy of this notice upon request. (an electronic version of this notice is on our website at **www.mass.gov/gic**.

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the *GIC* or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your *GIC* benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 801 or TTY for the deaf and hard of hearing at (617)-227-8583.

Need to Write or Call?

Tufts Health Plan
705 Mt. Auburn Street, P.O. Box 9173
Watertown, MA 02471-9173

1-800-870-9488

Commonwealth of Massachusetts
Group Insurance Commission

TUFTS Health Plan
No one does more to keep you healthy.

Tufts Health Plan
705 Mt. Auburn Street
Watertown, MA 02472

For additional information,
please call 1-800-870-9488

www.tuftshealthplan.com

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